www.ijip.in | ISSN: 2348-5396 (e) | ISSN: 2349-3429 (P)

Volume: 4, Issue: 2, January-March, 2017

DIP: 18.01 | IF. 6.9 (ICI) | No. 92

# The International Journal of INDIAN PSYCHOLOGY

## Person of the Month

## Carl R. Rogers (1902-1987)



ISSN 2348-5396

9 772348 539009

The International Journal of
INDIAN PSYCHOLOGY

Volume 4
**Issue 2, No. 92**
January – March 2017

**THE INTERNATIONAL JOURNAL OF INDIAN PSYCHOLOGY**

This Issue (Volume 4, Issue 2, No. 92) Published, March, 2017
-- -- -- -- -- -- -- -- -- -- -- -- --
**Headquarters;**
REDSHINE Publication, 88, Patel Street, Navamuvada, Lunawada, Gujarat, India, 389230
Author Helpline: +91 76988 26988



-- -- -- -- -- -- -- --

ISSN (Online) 2348-5396
ISSN (Print) 2349-3429
ZDB: 2775190-9
IDN: 1052425984
CODEN: IJIPD3
OCLC: 882110133
WorldCat Accession: (DE-600) ZDB2775190-9
ROAR ID: 9235
Impact Factor: 6.9 (2015) from the ICI
ISBN: 978-1-365-78192-6 (eBook)
-- -- -- -- -- -- -- --

Price: 500 INR/- | $ 8.00 USD
2017 Edition

Website: www.ijip.in
Email: info.ijip@gmail.com

Please submit your work's abstract or introduction to ( info.ijip@gmail.com | www.ijip.in)

**IJIP's all content automatic indexed to Google Scholar, Google Book Programs.**

**Ajay Chauhan, M.Phil**
*Clinical Psychology, Sardar Patel University, Vallabh Vidyanagar*
*INDIA*

**Richard Harvey (Psycho-Spiritual Psychotherapist)**
*Author and Spiritual Teacher, Founder-Director of the Change Workshops (1986–1995).*
*SPAIN*

**Vishal Parmar, Forensic Psychologist**
*Forensic Psychology, Institute of Behavioural Science, Gujarat Forensic Sciences University, Gandhinagar, Gujarat.*
*INDIA*

**Aastha Dhingra (Clinical Psychologist)**
*DIRECTOR & CO-FOUNDER, AD EXECUTIVE TRAINING & COACHING PVT LTD*
*INDIA*

# Message from the Desk of Editor

It gives me great opportunity to present the forth volume of IJIP, the measure of progress. The concept of a Journal of Indian Psychology has been developing for over few years and finally another issue has come to fruition. From this edition we have ISSN for online 2348-5396 and print 2349-3429, ZDB-No.: 2775190-9, IDN: 1052425984, CODEN: IJIPD3, OCLC: 882110133, WorldCat Accession: (DE-600) ZDB2775190-9, ResearchID: P-8455-2015 in our publication. RedShine Publication, Inc is grateful to the contributors for making this Journal a reality.

The aim of IJIP is to increase the visibility and ease of use of open access scientific and scholarly articles thereby promoting their increased usage and impact. Hence, IJIP grants the permission to read, download, copy, distribute, print, search or link to the full texts of articles available online at the IJIP officially website (www.ijip.in) freely. Authors do not have to pay for submission, review of articles in IJIP.

The Journal would publish peer-reviewed original research papers, case reports, systematic reviews and meta-analysis. Editorial, Guest Editorial, Viewpoint and letter to the editor are solicited by the editorial board. Large numbers of research papers were received from all over the globe for publication and we thank each one of the authors personally for soliciting the journal. We also extend our heartfelt thanks to the reviewers and members of the editorial board who so carefully perused the papers and carried out justified evaluation. Based on their evaluation, we could accept some research papers for this issue across the disciplines. We are certain that these papers will provide qualitative information and thoughtful ideas to our accomplished readers. We thank all the readers profusely who conveyed their appreciation on the quality and content of the journal and expressed their best wishes for future issues. We convey our deep gratitude to the Editorial Board, Advisory Board and all office bearers who have made possible the publication of this journal in the planned time frame.

We humbly invite all the authors and their professional colleagues to submit their research papers for consideration for publication in our upcoming issues as per the "Scope and Guidelines to Authors" given at the website. Any comments and observations for the improvement of the journal are most welcome.

**Prof. Suresh Makvana, PhD**[1]
Editor in Chief,
HOD & Professor, Dept. of Psychology,
Sardar Patel University,
Vallabh Vidyanagar,
Gujarat, India

[1] ksmnortol@gmail.com

Index of Volume 4, Issue 2, No.92

The present issue of the journal is edited & published by RED'SHINE Publication (A unit of RED'MAGIC Networks. Inc) at 86/Shardhdha, 88/Navamuvada, Lunawada, Gujarat-389230, India

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 85, DIP: 18.01.001/20170402
ISBN: 978-1-365-68608-5
http://www.ijip.in | January-March, 2017

# Person of the Month: Carl R. Rogers (1902-1987)

Ankit Patel[1]

| | |
|---|---|
| **Born** | January 8, 1902<br>Oak Park, Illinois, U.S. |
| **Died** | February 4, 1987<br>San Diego, California, U.S. |
| **Citizenship** | American |
| **Known for** | Client-centered therapy, Student-centered learning, Rogerian argument |
| **Fields** | Phenomenal field, Theoretical works |

Carl Ransom Rogers was an American psychologist and among the founders of the humanistic approach in psychology. The person-centered approach, his own unique approach to understanding personality and human relationships. Throughout his career he dedicated himself to humanistic psychology and is well known for his theory of personality development. He began developing his humanistic concept while working with abused children. Rogers attempted to change the world of psychotherapy when he boldly claimed that psychoanalytic, experimental, and behavioral therapists were preventing their clients from ever reaching self-realization and self-growth due to their authoritive analysis. He argued that therapists should allow patients to discover the solution for themselves. Rogers received wide acclaim for his theory and was awarded various high honors.

Dr. Carl R. Rogers was born in Oak Park, Illinois, in 1902. He received his B.A. from the University of Wisconsin in 1924, a M.A. from Columbia University in 1928, and his Ph.D. in psychotherapy from Columbia University in 1931. In 1940 Rogers became professor of psychology at Ohio State University where he stayed until 1945. He then transferred to the University of Chicago in 1945 where he served as the professor of psychology and the executive secretary at the Counseling Center. In 1957 he took a jpoint position in the departments of

[1] Clinical Psychology, Dept. of Psychology, Sardar Patel University, Vallabh Vidyanagar, Gujarat
**Received: December 28, 2016; Revision Received: January 5, 2017; Accepted: January 24, 2017**

psychology and psychiatry at the University of Wisconsin. After this Rogers traveled to a variety of colleges.

Rogers is a leading figure within psychotherapy and developed a breaking theory of personality development. This theory developed as a result of Rogers frustration with the authoritive analysis that therapists were imposing upon their patients. He is well known for his emphasis on personal awareness and allowing clients to have increasing flexibility in determining the treatment. Rogers believed that it was important for the individual to learn to understand himself and make independent choices that are significant in understanding the problem.

## ROGERS' THEORY

Theory of Personality Development Rogers' therapy was an extension of his theory of personality development and was known as client-centered therapy, since the basis of the therapy was designed around the client. According to Rogers each person has within them the inherent tendency to continue to grow and develop. As a result of this the individual's self-esteem and self-actualization is continually influenced. This development can only be achieved through what Rogers refers to as "unconditional positive regard."

The element of free expression can also be illustrated in the case Mrs. L, and her ten- year- old son, Jim. During the first hour of the session the mother spent a full half-hour telling with intense feeling example after example of Jim's bad behavior. She tells of arguments with his sister, his refusal to dress himself, annoying tendencies such as humming at the table, bad behavior in school, and his refusal to help at home. Each one of her comments is highly critical of her son. Throughout the mothers talking the counselor makes no attempt to persuade the mother in feeling any other way about her son. Next, the son engages in play -therapy in which Jim makes a clay image and identifies it as his father. There is a great deal of dramatic play in which the boy shows his struggle in getting his father out of bed and the fathers resistance. Throughout this Jim knocks the clay figurines head off and crushes the body while shouting frantically. In both occurrences with the mother and her son the counselor allows the feelings to flow and does not try to block or alter them.

Another aspect of the therapy is that of positive action. Here once insight is achieved the actions that are taken are suited to the new insight that is gained. Thus, once Mrs. L has achieved a better emotional understanding of the relationship between herself and her son she is able to transfer that insight into actions which show the depth of her insight. She plans on giving Jim special affection, helping him to be more mature, and avoiding making the younger sister jealous. If such behavior had been suggested to her after the diagnosis of the case, she would have either rejected the suggestion or carried it out in a way that would almost certainly fail. Since it grew out of her own insight, she will be able to become a successful, mature mother.

The methodology of Rogers theory proved to be very successful within the case of Mrs. L and her son. This approach has helped millions of people since Rogers first developed it.

## TIMELINE

1902 Born in Oak Park, Ill.
1924 Completed B.A., University of Wisconsin
1928 M.A., Columbia University
1931 Ph.D., Columbia University, Psychotherapy
1940 Ohio State University, Columbus, professor of psychology
1944 President of the American Association for Applied Psychology
1945 University of Chicago, Chicago, Ill., Professor of Psychology and executive secretary , Counseling Center.
1946 President of the American Psychological Association
1955 Nicholas Murray Butler Silver Medal
1956 First President of American Academy of Psychotherapist and special contribution award, American Psychological Association
1957 professor in departments of psychology and psychiatry; University of Wisconsin
1960 member of executive committee, University of Wisconsin
1962 Fellow, Center for Advanced Study in the Behavioral Sciences
1964 selected as humanist of the year, American Humanist Association
1968 honorary doctorate, Gonzaga University
1971 D.H.L. , University of Santa Clara
1972 distinguished professional psychologist award, Division of Psychotherapy
1974 D.Sc. university of Cincinnati
1975 D.Ph. University of Hamburg and DS.Sc. University of Leiden
1978 D.Sc. Northwestern University
1984 Union for Experimenting Colleges and Universities, Cincinnati
1987 Died of heart attack, San Diego, California

## REFERENCES

Hothersall, David. (1995) History of Psychology. New York: McGraw-Hill.

Kathy Jo Hall (1997), Carl Rogers, Retrieved from http://www.muskingum.edu/~psych/psycweb/history/rogers.htm [15 Jan 2017]

May, Hal and collaborators. (1987). "Carl Rogers" Contemporary Authors, Vol.121, pg 363.

Metzger, Linda. and Straub Deborah. "Carl Rogers" Contemporary Authors New Revision Series, Vol 18 pg 381-382.

Rogers, C. (1942) Counseling and Psychotherapy. Houghton Mifflin Company, pg 31-44.

Rogers, C. (1951) Client-Centered Therapy. Houghton Mifflin Company, pg 13, 71.

Rogers, C. (1961) On Becoming a Person. Houghton Mifflin Company, pg 16, 17, 34.

Rogers, Carl R, Lyon, Harold C., Tausch, Reinhard: (2013) On Becoming an Effective Teacher - Person-centered Teaching, Psychology, Philosophy, and Diologues with Carl R. Rogers and Harold Lyon. London: Routledge

Rogers, Carl. (1951). Client-Centered Therapy. p. 64

Rogers, Carl. Communication: Its Blocking and Its Facilitation. [On Becoming a Person. Boston: Houghton Mifflin, 1961. 329-337.]

**Photo Credit: Erikerikson.org**

**How to cite this article:** A Patel (2017), Person of the Month: Carl R. Rogers (1902-1987), International Journal of Indian Psychology, Volume 4, Issue 2, No. 85, ISSN 2348-5396 (e) | ISSN: 2349-3429 (p), DIP: 18.01.001/20170402, ISBN: 978-1-365-68608-5

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.101/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Epidemiology of Mental Health and Mental Health Issues of Women in India: A Literature Review

Amit Das[1]*

**ABSTRACT**

Worldwide 450 million (12%) people suffer from disability and this will be increased up to 15% in the year 2020, as per WHO estimation. Psychiatric Epidemiological studies in India from 1964 to 2001, shows increasing trends of mental health morbidity prevalence from 9.5 to 102.8 per 1000 population and new incidence cases were over 16.0 per 1000 population. A study reported that overall life time prevalence of mental disorder to be around 5%. Depression, anxiety, and unspecified psychological distress are 2–3 times more common among women compare to men. Common Mental Disorders is common among poor women and the causes may be hormonal factors (reproductive cycle may play a role of increased vulnerability to depression), other factors are excessive partner, alcohol use, sexual, physical violence by the husband, being widowed or separated, having low autonomy in decision making, and low levels of support from one's family. Illiteracy and women mental health is significantly associated in India. Suicide and rape also related to mental health issues in Indian women. In 2012, National Crime Records Bureau reported 24,923 rape cases and among them 98% being committed by someone known to victims. Studies found that girls from nuclear families and women married at a very young age are in higher risk for committing suicide. To reduce these problems, Indian Constitution made several articles and acts to safeguard the disabilities/issues including women. Several NGO's and VO's are also working for the development of this section.

***Keywords:*** *Epidemiology, Mental Health*

The World Health Organization's Ottawa Charter for Health Promotion in 1986, sees health as multidimensional and espouses a social model of health. It defines health as 'a positive concept emphasizing social and personal resources, as well as physical capacities (World Health Organization, 1986).

[1] Research Scholar, Department of Social Work, Assam University, Silchar, Assam, India
*Responding Author

**Received: January 29, 2017; Revision Received: February 15, 2017; Accepted: February 24, 2017**

WHO report on the social dimensions of mental health, which states that: 'Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities involves cognitive, affective and relational, the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality (World Health Organization, 1981). This definition does not mention gender, but gender can and does impact on the production of mental health at every level - the individual, the group and the environment- and is critically implicated in the differential delivery of justice and equality. Gender configures both the material and symbolic position women occupy in the social hierarchy as well as the experiences which condition their lives.

Women and men differ in the way they communicate, deal in relationships, express their feelings, and react to stress. Thus, the gender differences are based in physical, physiological, and psychological attributes. There are psychological theories that present a gender sensitive viewpoint called as alpha bias, and there are others that are gender neutral representing beta bias. Alpha bias proposes that men and women are different and opposite, and in beta bias differences between men and women are ignored. Alpha bias is seen in psychodynamic theories and therapies where according to Freudian viewpoint, male anatomy and masculinity is the most desired and cherished goal and female anatomy and femininity are seen as a deviation. In contrast, the cognitive theories, behavioral theories, and humanistic-existential theories have beta bias (Hare-Mustin and Marecek, 1988). It is necessary to understand and accept that women and men differ in biological attributes, needs, and vulnerabilities.

The importance of gender differences in mental health is most graphically illustrated in the significantly different rates of major depression experienced by women compared with men. A recent comprehensive review, Gender Differences in the Epidemiology of Affective Disorders and Schizophrenia, found that women predominated over men in lifetime prevalence rates of major depression in all the general population studies conducted so far (Piccinelli and Homen, 1997).

Beginning with the Second World War, epidemiology has grown by leaps and bounds all over the world, even though gross disparities are noticed even today, both between and within countries in its development and application. This branch of community and clinical medicine, means literally 'on the people', indicating study of populations. Epidemiology as a branch of public health has also grown in principles, methods and applications over a period of time (Park, 2002). Epidemiology is defined as 'the study of distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems' (Last, 1988). Psychiatric epidemiology is the study of the distribution and determinants of mental illness frequency in human beings, with the fundamental aim of understanding and controlling the occurrence of mental illness. Psychiatric epidemiology deals

with important components such as disease/disorder, distribution and frequency of disease/disorder, determinants of disease/disorder, human population and methods employed to control the occurrence of illness (Aschengrau and Seage, 2003).

## METHODS

Secondary data collection method was followed for this review study. The authors searched articles and reports from several journals which were published in PubMed, Google Scholar, CrossRef, Google, etc. from the year 1964 to 2012. The authors accepted both published and unpublished works. Out of 86 searched publications, a total 49 articles were included for this review. The search engine consists of both research papers and review papers.

## RESULTS AND DISCUSSION

### *Epidemiological studies of mental health in India*

WHO estimated that globally over 450 million people suffer from mental disorders and currently mental and behavioral disorders account for about 12 percent of the global burden of diseases. This is likely to increase to 15 percent by 2020. Major proportions of mental disorders come from low and middle income countries (World Health Organization, 2001). So, globally the issues of mental health considered one of the health issues that people suffers. Descriptive epidemiological studies have provided data about the prevalence of mental disorders in the community. However, many researchers have expressed reservations about the comparison of various epidemiological studies because of methodological differences. Varying prevalence rates have been reported in international studies like the Epidemiological Catchment Area Program and the National Co-morbidity Survey (Regier *et al.,* 1998, Murphy *et al.,* 2000).

Psychiatric epidemiology has kept its place with the general growth of psychiatric research in India. (Wig and Akhtar, 1974) mentioned that psychiatric research itself has grown by leaps and bounds in India since the time of independence. Wig clearly classifies this during the periods 1947–1960 (a slow phase of growth due to the lack of researchers and clarity issues) and 1960–1972 (a period of psychiatric epidemiological surveys and some focused studies). (Kessler, 1999) expressed about global developments of psychiatric epidemiology. (Murthy, 1987) mentioned that, India has not lagged behind in the growth of psychiatric epidemiology.

Epidemiological studies divided into several types i.e., prevalence study, incidence study, and follow up study. Prevalence studies can be simply defined as total number of persons in the population who have disease/problems at a point or period in time. It refers to both old and new cases. If the observational period is at a given point in time it is called as 'point prevalence' and if it is at a given specific period in time it is called as 'period prevalence'(Park, 2007). Most of the community-based Indian epidemiological studies are on point prevalence which summarizes the prevalence of psychiatric morbidity in the general population. These community-based

epidemiological studies (Table 1) conducted in India on mental and behavioral disorders report varying prevalence rates, ranging from 9.5 to 102.8 per 1000 population.

***Table 1: Prevalence of psychiatric morbidity and incidences from Indian Epidemiological studies***

| Investigator/s | Centre | Sampling | Tool used | Population | Prevalence per 1000 | Incidence per 1000 |
|---|---|---|---|---|---|---|
| Surya, 1964 | Pondicherry | H-H | MHSQ(P) | 2731 | 9.5 | |
| Dube, 1970 | Agra | H-H | DCP | 29,468 | 18.0 | |
| Elnager et al, 1971 | Hoogly | H-H | CHM and DCP(2) | 1393 | 27.0 | |
| Sethi et al, 1972 | Lucknow | H-H | CHQ and CHM | 2691 | 39.4 | |
| Verghese et al., 1973 | Vellore | SRS | MHIS and DCP | 1887 | 66.5 | |
| Sethi et al, 1974 | Lucknow | 3SPS | PSQ and DCP | 4481 | 67 | |
| Thacore et al., 1975 | Lucknow | H-H | PHQ and DCP | 1977 | 81.6 | |
| Nandi et al., 1975 | West Bengal | H-H | HS, QS and CRS | 1060 | 102.8 | |
| Nandi et al.,2000 | West Bengal | H-H | HS, QS and CDS | 1060 | | 17.6 |
| Nandi et al., 1976 | West Bengal | H-H | HS, CDS and CRS | 2230 | | 16 |
| Nandi et al., 1979 | West Bengal | H-H | HS, SESS, CDS, & CRS | 3718 | 102 | |
| Shah et al., 1980 | Ahmedabad | H-H | MHSQ and DCP | 2712 | 47.2 | |
| Mehta et al., 1985 | Vellore | S-S | IPSS and DCP | 5941 | 14.5 | |
| Sachdeva et al., 1986 | Faridkot | H-H | HS, SESS and CDS | 1989 | 22.12 | |
| Premrajan et al., 1993 | Pondicherry | RS | IPSS and DCP | 1115 | 99.4 | |
| Shaji et al., 1995 | Erankulam | H-H | IPSS, SESS, CRS & DCP | 5284 | 14.57 | |
| Sharma and Singh, 2001 | Goa | SRS | RPES and DCP | 4022 | 60.2 | |

***Abbreviation** - H-H - House to house survey, S-S - Systematic sampling, SRS - stratified random sampling, 3SPS - 3-stage probability sampling, RS - random sampling, ICD - International classification of diseases, DSM-II - diagnostic and statistical manual of mental disorders. Tools: MHSQ = Mental health screening questionnaire, DCP = Diagnosis confirmed by a psychiatrist (S), CHM = Case history method, CHQ = Case history questionnaire, IPSS = Indian Psychiatric survey schedule, SFQ = Social functioning questionnaire, MHIS = Mental health item sheet, PSQ = Psychiatric screening questionnaire, PHQ = Psychiatric health questionnaire, HS = Household schedule, QS = Questionnaire schedule, CRS = Case record schedule, CDS = Case detection schedule, SESS = Socioeconomic status schedule, RPES = Rapid psychiatric examination schedule*

***Source: Math et al., 2007***

A study conducted in Pune in 2012 reported the overall life time prevalence of mental disorders to be nearly 5 percent (Deswal and Pawar, 2012). Only two studies conducted on incidence which shows that the incidence was over 16 per 1000 population. In India, less numbers of incidence studies conducted and the result shows an increasing trend compare to WHO

prediction of 2020. India is a developing country and increasing trend of mental health disorders/issues may lead its health and economy.

***Understanding mental health issues and disorders in India***

Worldwide, gender is a critical determinant of mental health and mental illness. Symptoms of depression, anxiety, and unspecified psychological distress are 2–3 times more common among women compare to men (World Health Organization, 2001). From the various literature reviews it has found that majority of women in India, during their life-span faces several problems like domestic violence, particularly spousal violence, dowry related stressors, and poor family support.

Females are more predisposed to mental disorders due to rapid social change, gender discrimination, social exclusion, gender disadvantage like marrying at young age, concern about the husband's substance misuse habits, and domestic violence (Patel and Kleinman, 2003). Poorer women are more likely to suffer from adverse life events, to live in crowded or stressful conditions, to have fewer occupational opportunities and to have chronic illnesses; all of these are recognized risk factors for common mental disorders (Kermode *et al*., 2007). A study on National Literacy Mission in Northern India shows there is an association between female illiteracy and poor mental health (Cohen, 2002). Community-based studies and studies of treatment seekers in India indicate that women are on average, 2–3 times, at greater risk to be affected by common mental disorder (Thara and Patel, 2001). This may be due to hormonal factors related to the reproductive cycle may play a role in women's increased vulnerability to depression (Parry, 2000). Another factor may be include excessive partner alcohol use, sexual, and physical violence by the husband, being widowed or separated, having low autonomy in decision making, and having low levels of support from one's family (Patel *et al*., 2006, Shidhaye and Patel, 2010, Nayak *et al*., 2010). There are a number of potential factors, which increase vulnerability of women to common mental disorder. The reproductive roles of women, such as her expected role of bearing children, the consequences of infertility and the failure to produce a male child, have been linked to wife battering and female suicide (Davar, 1999, Dennerstein *et al*., 1993). Suicide is another serious mental health problem of women in India. The common causes for suicide in India are disturbed interpersonal relationships followed by psychiatric disorders and physical illness (Rao, 2004). A study found that girls from nuclear families and women married at a very young age, to be at a higher risk for attempted suicide and self-harm (Biswas *et al*., 1997). Indian women are also facing the problems of rape and it is the fourth most common crime in India against women (Kumar, 1993). National Crime Records Bureau, 2012, reported that in India there were 24,923 rape cases in the year 2012, and among them 98% being committed by someone known to the victim.

Indian constitution made several articles and acts to deal with such disabilities from our society and these were implemented in national, state, district, and block levels. Several non-

governmental organizations (NGOs) and voluntary organizations (VOs) in India are also working for the development of women and their associated mental disorders/issues.

## CONCLUSION

Epidemiology of mental health in India shows that there is an increasing trend of mental health morbidities from 9.5 to 102.8 per 1000 persons. Generally women were facing issues of common mental disorders (CMD) which includes depression, anxiety, domestic violence, suicide, rape, etc. These types of disorders/issues female have 2-3 times more compare to males. So, these are the matter of concern and accordingly for preventive measures Indian constitution made several articles and acts. Apart from this several NGOs and VOs are working and also need to work for the development of women in respect of problems of their mental disorders/issues.

***Acknowledgments***

The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Aschengrau, A., & Seage, G. R. (2003). *Essentials of epidemiology in public health*. 3rd (ed). Pub: Jones and Bartlett, Sudbury, Massachusetts.

Biswas, S., Roy, S., Debnath, C., & Sengupta, S. B. (1997). A study of attempted suicide in adolescents in West Bengal. *Indian Journal Of Psychiatry*, 39, 54 – 55.

Cohen, A. (2002). *Our lives were covered in darkness.* In: Cohen A, Kleinman A, Saraceno B, eds. The Work of the National Literacy Mission in Northern India, Chapter 5, World Mental Health Case Book. New York: Kluwer Academic/Plenum Publishers.

Crime in India. (2012). Statistics. *National Crimes Record Bureau*, Ministry of Home Affairs, Government of India. Available from website: http://www.ncrb.nic.in/CD-CII2012/Statistics2012.pdf. Retrieved on 12/12/2016.

Davar, B. (1999). *The Mental Health of Indian Women: A Feminist Agenda*. New Delhi: Sage publication.

Dennerstein, L., Astbury, J., & Morse, C. (1993). *Psychosocial and Mental Health Aspects of Women's Health.* WHO/FHE/ MNH/93.1. Geneva: World Health Organization.

Deswal, B. S., & Pawar, A. (2012). An Epidemiological Study of Mental Disorders at Pune, Maharashtra. *Indian J Community Med*, 37(2), 116 – 121.

Dube, K. C. (1970). A Study of prevalence and biosocial variables in mental illness in rural and urban community in Uttar Pradesh, India. *Acta Psychiatr Scand*, 46, 327 – 359.

Elnager, M. N., Maitra, P., & Rao, M. N. (1971). Mental health in an Indian rural community. *Br J Psychiatry*, 118, 499 – 503.

Geneva: World Health Organization. (2001). World Health Organization. Gender and women's mental health. Gender disparities and mental health: *The Facts.*

Hare-Mustin, R. T., & Marecek, J. (1988). The meaning of difference. Gender theory, postmodernism and psychology. *Am Psychol*, 43, 455–64.

Kermode, M., Herrman, H., Arole, R., White, J., Premkumar, R., & Patel, V. (2007). Empowerment of women and mental health promotion: a qualitative study in rural Maharashtra, India. *BMC Public Health*, 7, 225.

Kessler, R. C. (1999). The World Health Organization International Consortium in Psychiatric Epidemiology (ICPE): Initial work and future directions — The Nape Lecture 1998a. *Acta Psychiatrica Scandinavica*, 99, 2 – 9.

Kumar, R. (1993). The History of Doing: An Account of Women's Rights and Feminism in India. *Zubaan*, 128.

Last, J. M. (1988). *A Dictionary of Epidemiology*, 2nd (ed). New York: Oxford University Press.

Math, S. B., Chandrashekar, C. R., & Bhugra D. (2007). Psychiatric epidemiology in India. *Indian J Med Res*, 126, 183 – 192.

Mehta, P., Joseph, A., & Verghese, A. (1985). An epidemiological study of psychiatric disorders in a rural area in Tamil Nadu. *Indian J Psychiatry*, 27, 153 – 158.

Murphy, J. M., Monson, R. R., Laird, N. M., Sobol, A. M., & Leighton, A. H. (2000). A comparison of diagnostic interviews for depression in the Stirling County study: Challenges for psychiatric epidemiology. *Arch Gen Psychiatry*, 57, 230 – 236.

Murthy, R. S. (1987). *Overview of Psychiatric Epidemiology in India* (unpublished). Workshop on research issues in psychiatric epidemiology in India.

Nandi, D. N., Ajmany, S., Ganguli, H., Banerjee, G., Boral, G. C., & Sarkar, S. (1976). The incidence of mental disorders in one year community in West Bengal. *Indian J Psychiatry*, 18, 79 – 87.

Nandi, D. N., Ajmany, S., Ganguly, H., Banerjee, G., Boral, G. C., Ghosh, A., et al. (1975). Psychiatric disorders in a rural community in West Bengal: An epidemiological study. *Indian J Psychiatry*, 17, 87 – 99.

Nandi, D. N., Banerjee, G., Boral, G. C., Ganguli, H., Ajmany, S., Ghosh, A., et al. (1979). Socio-economic status and prevalence of mental disorders in certain rural communities in India. *Acta Psychiatr Scand*, 59, 276 – 293.

Nandi, D. N., Banerjee, G., Mukherjee, S. P., Ghosh, A., Nandi, P. S., & Nandi, S. (2000). Psychiatric morbidity of a rural Indian community: Changes over a 20-year interval. *Br J Psychiatry*, 176, 351 – 356.

Nayak, M. B., Patel, V., Bond, J. C., & Greenfield, T. K. (2010). Partner alcohol use, violence and women's mental health: Population-based survey in India. *Br J Psychiatry*, 196, 192 – 199.

Park, K. (2002). *Park's Textbook of Preventive & Social Medicine*. 17th (ed). Jabalpur: Banarsidas Bhanot.

Park, K. (2007). *Park's Textbook of Preventive & Social Medicine.* 19th (ed). Jabalpur: Banarsidas Bhanot.

Parry, B. L. (2000). *Hormonal basis of mood disorders in women. In: Frank E, editor. Gender and Its Effects on Psychopathology*. Washington DC: American Psychiatric Press, 61–84.

Patel, V., & Kleinman, A. (2003). *Poverty and common mental disorders in developing countries.* Bull World Health Organ, 81(8), 609 – 615.

Patel, V., Kirkwood, B. R., Pednekar, S., Pereira, B., Barros, P., Fernandes, J., et al. (2006). Gender disadvantage and reproductive health risk factors for common mental disorders in women: A community survey in India. *Arch Gen Psychiatry*, 63, 404 – 413.

Piccinelli, M., & Homen, F. G. (1997). Gender differences in the epidemiology of affective disorders and schizophrenia. Geneva: *World Health Organization.*

Premrajan, K. C., Danabalan, M., Chandrasekhar, R., & Srinivasa, D. K. (1993). Prevalence of psychiatric morbidity in an urban community of Pondicherry. *Indian J Psychiatry*, 35, 99 – 102.

Rao, V. (2004). *Suicidology: The Indian context. In: Agarwal SP, editor. Mental Health: An Indian Perspective* 1946-2003. New Delhi: Directorate General of Health Services/Ministry of Health and Family Welfare Nirman Bhawan, 279 – 284.

Regier, D. A, Kaelber, C. T., Rae, D. S., Farmer, M. E., Knauper, B., Kessler, R. C., et al. (1998). Limitations of diagnostic criteria and assessment instruments for mental disorders: Implications for research and policy. *Arch Gen Psychiatry*, 55, 109 – 115.

Sachdeva, J. S., Singh, S., Sidhu, B. S., Goyal, R. K. D., & Singh, J. (1986). An epidemiological study of psychiatric disorders in rural Faridkot (Punjab). *Indian J Psychiatry*, 28, 317 – 323.

Sethi, B. B, Gupta, S. C., Mahendru, R. K., & Kumari, P. (1972). A psychiatric survey of 500 rural families. *Indian J Psychiatry*, 14, 183 – 196.

Sethi, B. B., Gupta, S. C., Mahendru, R. K., & Kumari, P. (1974). Mental Health and urban life: A study of 850 families. *Br J Psychiatry*, 124, 243 – 246.

Shah, A. V., Goswami, U. A., Maniar, R. C., Hariwala, D. C., & Sinha, B. K. (1980). Prevalence of psychiatric disorders in Ahmedabad: An epidemiological study. *Indian J Psychiatry*, 22, 384 – 388.

Shaji. S., Verghese, A., Promodu, K., George, B., & Shibu, V. P. (1995). Prevalence of priority psychiatric disorders in a rural area of Kerala. *Indian J Psychiatry*, 37, 91 – 96.

Sharma, S., & Singh, M. M. (2001). Prevalence of mental disorders: An epidemiological study In Goa. *Indian J Psychiatry*, 43, 118 – 126.

Shidhaye, R., & Patel, V. (2010). Association of socio-economic, gender and health factors with common mental disorders in women: A population-based study of 5703 married rural women in India. *Int J Epidemiol*, 39, 1510 – 1521.

Surya, N. C. (1964). *Mental morbidity in Pondicherry*. *Transaction-4*, Bangalore: All India Institute of Mental Health.

Thacore, V. R., Gupta, S. C., & Suriya, M. (1975). Psychiatric Morbidity in North Indian Community. *Br J Psychiatry*, 126, 364 – 369.

Thara, R., & Patel, V. (2001). *Women's mental health: A public health concern*. Regional Health Forum-WHO South-East Asia Region, 5, 24–34.

Verghese, A., Beig, A., Senseman, L. A., Sundar Rao, P. S., & Benjamin, V. (1973). A social and psychiatric study of a representative group of families in Vellore town. *Indian J Med Res*, 61, 608 – 620.

Wig, N. N., & Akhtar, S. (1974). Twenty-five years of psychiatric research in India. *Indian Journal of Psychiatry*, 16, 48 – 64.

World Health Organization, *Health and Welfare Canada. (1986). Ottawa charter for health promotion Canadian Public Health Association*. Retrieved on 14/12/2016.

World Health Organization. (1981). *Social dimensions of mental health* (5). Geneva.

World Health Organization. *The world health report.* (2001). Mental Health: New Understanding, New Hope. World Health Organization 2001, Geneva.

**How to cite this article:** Das A (2017), Epidemiology of Mental Health and Mental Health Issues of Women in India: A Literature Review, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.101/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.102/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Women Mental Health and Well-being: A New Paradigm

Mrs. Ashwini. R[1]*, Dr. Vijay Prasad. B[2]

**ABSTRACT**

This paper reviews literature on the determinants of women's mental health through a stigma of mental illness and gender perspectives. This approach stresses that women's particular health needs have been neglected in a male-centred models of health, and argues for the importance of addressing these needs in a way that views women and their lives holistically. A woman in social context is seen as parents and their roles have been demonstrated from their life within the family and society as well. This article draws attention to the women and physical health instead of looking at mental illness alone. The impact of violence against women, in particular, the effects of childhood sexual abuse, domestic violence and rape has been illustrated in western and Indian perspectives. In recommendations initiatives in mental health services especially, for women mental health has been emphasized broadly.

***Keywords:*** *Gender, Stigma, Mental Disorder, Wellbeing*

**H**ealth and wellbeing in general is a Nobel concept of human kind to measure their quality of life. The definition of health by The World Health Organization (WHO) defined health in its broader sense in 1946 as "*a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity*." Similarly, mental health encompasses components of psychological, physical and social well-being. The public health paradigm has gained increasing viability as an alternative, complimentary approach to the medical model. It re-establishes a balanced view of both illness prevention and health promotion. Mental health promotion is any action taken to maximize mental health and well-being among populations and individuals, whereas mental health prevention is concerned with avoiding illness. In 1986, the World Health Organisation defined health promotion as the process of enabling people to increase control over and to improve their health (WHO, 1986). In order to achieve better mental health outcomes for

[1] Clinical Psychologist, Dept of Clinical Psychology, Dharwad Institute of Mental Health and Neurosciences (DIMHANS)-Dharwad-Karnataka, India
[2] Associate Professor, Dept., of Clinical Psychology, Dharwad Institute of Mental Health and Neurosciences (DIMHANS)-Dharwad-Karnataka, India
*Responding Author

**Received: January 09, 2017; Revision Received: February 16, 2017; Accepted: February 24, 2017**

women and men we need to tackle the social context of individual behaviour and empower individuals and communities to make positive change.

***Mental disorders***

Prevalence rates of depression and anxiety disorders as well as psychological distress are higher for women than for men. These findings are consistent across a range of studies undertaken in different countries and settings (Desjarlais et al., 1995). In addition to the higher rates of depression and anxiety, women are much more likely to be diagnosis diagnosed for obsessive compulsive disorder, somatisation disorder and panic disorder (Russo, 1990). In contrast men are more likely to be diagnosed for antisocial personality disorder and alcohol abuse/dependency. The gender differences associated with mental disorders are brought out most clearly in case of depression (Russo, 1990). Data from the World Bank study revealed that depressive disorders accounted for close to 30% of the disability from neuropsychiatric disorders amongst women in developing countries but only 12.6% of that among men. The disparity in rates between men and women tend to be even more pronounced in underserved populations (World Bank, 1993).

***Women's Mental Health***

Women represent a special group for mental health care. The need of women from mental health point is well recognized in all populations. Though the overall prevalence of mental and behavioral disorders is not different between men and women, anxiety and depressive disorders are more common among women. Almost all studies show that depressive disorders are 1.5 to 2 times of that in men, during the adult life. The reasons for these differences are partly biological, partly social and psychological. In addition women are more often the victims of domestic violence. Studies in developed countries have shown that women experiencing domestic violence have higher symptoms of psychological distress and greater frequency of contemplation of suicide (Thara, 2004). From all these perspectives, mental health needs of women are greater, of special nature and need interventions that are sensitive to their needs. Specific measures to care to this group would include the following strategies: greater number of women health personnel; specific training to health personnel on gender issues; mental health education about self-care for mental health; support to women to form self-help groups; emotional support at individual and family levels and income generating activities (Thara, 2004).

***Stigma of mental disorders in women***

Stigma of mental illness continues to be a major issue in India. Thara and Srinivasan (1998) reported on the beliefs about mental illness from a rural South-Indian community. Thara and Srinivasan (2000) studied the nature of stigma and its relationship to attribution in primary caregivers of 159 urban patients of Madras. Marriage, fear of rejection by neighbour, and the need to hide the fact from others were some of the more stigmatising aspects. Female sex of the patient and a younger age of both patient and caregiver were associated with higher stigma. Attributions to faulty biological functioning, character of lifestyle, substance abuse and intimate

interpersonal relationship discriminated between the groups with experiences of high and low stigma. Beliefs about causation of schizophrenia influence the attitudes of patients' families.

***Gender Perspectives***

Bringing up female plays a powerful role in shaping women's vulnerability to mental disorders (Taft, 2003), While women may have freed themselves to some extent from the gendered norms of the domesticity and economic dependence of previous generations, they still bear the greater unpaid burden of domestic chores and have not yet achieved economic independence. Women also continue to shoulder, disproportionately, the care of children and sick or elderly relatives. Studies show that combined risks of anxiety and depression have been found to be twice as high for women as for men (Australian Institute of Health and Welfare, 2008) This can, in part, be attributed to negative attitudes towards women, lack of acknowledgement of the work they do, fewer opportunities in education and employment and greater risk of domestic violence (WHO, 2000) Gender also intersects with a number of social factors to make some groups of women more vulnerable to poor mental health. These groups include women with disabilities, single mothers, culturally and linguistically diverse women, indigenous women and same-sex attracted women.

***Gender and the research data***

Few people working in mental health would disagree that 'gender is a critical determinant of mental health and mental illness' (WHO, 2008) yet, how many have a clear understanding of why, when we talk about mental health, we need to talk about women (and men), not just people? If we are going to meet sex-specific needs in mental health (and indeed, in health generally), a collection of raw data is not enough; it must be disaggregated or put more simply, count men and women separately. Gendered data seems so obvious, but if you read most government reports and examine much of the research, you will find that gender is often ignored or overlooked. Yet, without gender specific data, policy and program development can only tell part of the story and address only some of the issues.

How else can we know, other than through gender-based research and the data it produces, that 15 per cent of women (compared to ten per cent of men), report high to very high levels of psychological distress (Australian Bureau of Statistics, 2006), that women, while succeeding less, attempt suicide more than men, and that anxiety and depression in women is frequently accompanied by other mental health problems (Guggisberg, 2006). How can we reach women and deliver mental health services responsive to women most in need and understand what may trigger mental illness in women at particular stages of life? How can we plan, provide, tailor, fund and target policy and programs to women if we do not have gendered data available to us? And, how do we work to prevent women developing mental health problems if we do not have evidence to guide us? If we are to be sensitive to diversity as well as gender further disaggregation of gendered data by income, education, age, ethnicity, language, sexual

orientation, disability, Aboriginality and geographic location will alert us to the way gender interacts with other social factors to influence mental health. Of course, collection of this data not only helps to better tailor and target policy and programs to women, it will identify needs in male populations, too.

Health policy-makers and practitioners are beginning to recognize the importance of gender issues to health and health care. Interpretations of gender analysis in health fields have been varied but include two main approaches: a women's health needs approach and a gender-equity approach (Standing, 1997). A women's health needs approach is "concerned with the implications for women of difference in the epidemiological profile between the sexes" (Standing, 1997). This approach stresses that women's particular health needs have been neglected as a result of male-centred models of health, and argues for the importance of addressing these needs in a way which views women and their lives holistically; that is, it addresses the full range of women's health problems, rather than just their reproductive health problems, and that it does this throughout the life cycle.

A gender-equity approach is "concerned with the role of gender relations in the production of vulnerability to ill-health or disadvantage within health care systems" (Standing, 1997). So far, it has focused, in particular, on the influence of this on access to and utilization of formal health services. "Equity" can be distinguished from "equality" in that, while equality carries some notion of "sameness", equity carries a notion of "fairness". While a focus on equality would argue that men and women should be treated exactly the same – i.e. not discriminated against in the provision of health care explicitly on the basis of their sex – a focus on equity argues that men and women may have different needs and face different barriers to meeting those needs or to having them met. Additionally, different needs and barriers may not lead to equal disadvantage for both sexes. An equity approach, therefore, stresses that health policy must consider the different and inequitable needs of men and women in allocating resources for health promotion, prevention, and care (Liverpool School of Tropical Medicine, 1998).

In the past decade the number of women living in poverty has increased disproportionately to the number of men, particularly in developing countries. In addition to economic factors, the rigidity of socially ascribed gender roles and women's limited access to power, education, training and productive resources. While poverty affects households as a whole because of the gender division of labour and responsibilities for household welfare, women bear a disproportionate burden, attempting to manage household consumption and production under conditions of increasing scarcity (Nussbam, 2000).

***Women in Social context***

The relationship between poor physical health, impaired psychological functioning and deprived socio-economic background is well documented (Gomm, 1996). Women who display self-

neglect and self-harming behaviours are exposed to additional problems when trying to secure accommodation, training and employment. The 1992 Health and Lifestyles Survey found that community involvement and social support vary with socio-economic status. Women's health appeared more strongly associated with the social environment than men's (Cooper, Arber., & Fee, 1999). The quality and number of roles individuals play are important, with evidence that those with the fewest family, friendship, working and community roles have the poorest psychosocial health. More frequent and higher-quality social relationships in women can combat the effects of stress. However, individuals vary and we should avoid over-simplified factors for good mental health such as marriage and occupation (Pollock & West, 1987). For women, being part of an emotionally and economically rewarding social network would appear to be helpful in determining mental well-being, unless the demands upon the individual create emotional overload.

***Women as parents***

Parenting plays an important role, first, in protecting a child from harm and promoting physical and emotional health; second, in setting and enforcing boundaries to ensure the child's and others' safety; and, third, in optimizing the child's potential. Parenting can act as a buffer against adversity such as poverty or delinquent influences, but may also be a mediator of damage, as in child abuse. A reasonable consensus exists about 'bad parenting', but there is no agreement about its opposite. Although the job is complex and demanding, help is fragmented between different services and reactive in nature, doing little to involve the parent or take preventive action (Hoghughi, 1998). Mothers who themselves have had poor experiences of parenting may be the least likely to receive practical help with child care and social support to help them function in their new role (Pound & Abel, 1996). Lone teenage mothers are an especially vulnerable group. Women threatened with having their children taken into care may distrust services and feel inhibited from seeking help. A significant proportion of women with a severe mental illness have children, but health professionals tend to ignore these women's role as parents, considering parenting as a problem of social services rather than a health issue (Nicholson et al., 1993).

***Women's reproductive health***

Women with a mental illness may have less awareness of contraceptive needs, resulting in an increased risk of unwanted pregnancy. They may also be at increased risk of developing a sexually transmitted disease, more specifically having less knowledge of AIDS (Aruffo, Coverdale., & Chacko, 1990; Coverdale, Turbott., & Roberts, 1997).

***Women and abuse***

There has been increasing awareness of the impact of violence against women, in particular, the effects of *childhood sexual abuse*, *domestic violence and rape*.

These would be summarized in the following order:

*Childhood sexual abuse:* Women who have experienced childhood sexual abuse are more likely to suffer social, interpersonal and sexual difficulties in adult life. They seem to have particular problems with intimate relationships, owing to difficulties with trust and a perception of their partners as uncaring and over controlling. Abuse may also correlate with an increased risk for a range of mental health problems (Mullen, Martin., & Anderson, 1994).

*Domestic violence:* A high proportion of women attending accident and emergency departments report a history of domestic violence, and in this group there is a high level of mental health problems. A history of childhood abuse increases a woman's risk of subsequent mental health problems if she is also abused as an adult. In this double-abuse group, there may also be an increased risk of substance misuse (Roberts, Williams., & Lawrence, 1998).

*Rape:* Victims of completed rape are at increased risk of suicide attempts and of having a depressive illness. In addition, perceptions of life threat and actual injury increase the risk of post-traumatic stress disorder (PTSD) (Mezey & Stanko, 1996).

***Psychological wellbeing***

Ryff (1989) conceptualises psychological well-being as a positive component of mental health which can be viewed as a multi-faceted domain encompassing six distinct components, namely; positive self-regard (self-acceptance), mastery of the surrounding environment (environmental mastery), quality relations with others (positive relations with others), continued growth and development (personal growth), purposeful living (purpose in life), and capacity for self-determination (autonomy) (Ryff & Keyes, 1995). Research with Ryff's (1989) scale has revealed that psychological well-being develops through a combination of emotional regulation, personality characteristics, identity and life experience (Helson & Srivastava, 2001), increases with age, education, extraversion and conscientiousness and decreases through neuroticism (Keyes, Shmotkin & Ryff, 2002).

***Social wellbeing***

Social well-being may be conceptualised according to individuals' perception of social support. Procidano and Helier (1983) conception of perceived social support is understood as the extent to which the individual perceives that his/her needs for support, information and feedback are fulfilled by friends and family. The perception of social support plays an important role in coping behaviour of individuals.

## RECOMMENDATIONS FOR SPECIFIC INITIATIVES IN MENTAL HEALTH SERVICES

1. ***Upgrade the quality of mental health services***

   Mental health services have a crucial role to play in alleviating suffering associated with psychiatric illnesses, emotional distress, psychological disorders, and behavioural

pathology. Abused women, troubled children, those traumatized by political violence, those who have attempted suicide or are addicted to alcohol or narcotics, and especially those who suffer acute or chronic mental illnesses can be helped substantially by competent mental health care. We have seen how women suffer disproportionately from mental illnesses such as depression and anxiety, and dissociative disorders associated with sexual abuse, and yet these are the illnesses that competent clinicians may best help. With recent advances in psychiatric medications and specialized forms of psychosocial interventions, the potential for benefit is greater than at any time in history.

Yet mental health services in most societies are inadequate. Well-trained practitioners are scarce, drugs and psychosocial interventions are unavailable or of poor quality, and even where expertise and resources exist, they seldom reach into the communities where the needs are greatest. The human rights of the mentally ill are often severely compromised, and mental health care is too often associated with abusive social control. Financial investment is required for sustainable programs, and creativity is needed to build programs that join local resources with professional knowledge.

Mainstreaming a gender perspective in the mental health sector through educating women at all levels of society about the possibilities of mental health interventions and the potential for services and programs is central to the success of mental health program development. The development of community based programs may build upon the engagement of many women to their local communities and their commitment to community and family health. Formal mental health services, including rational drug policies for psychotropic medications and the reliable provision of adequate supplies at reasonable costs (selected generic antidepressants, antipsychotic and anticonvulsant drugs), must be complemented by non-medical support groups, consumer groups and healing institutions that provide crucial care in many communities.

2. ***Encourage systematic efforts to upgrade the amount and quality of mental health training for workers at all levels, from medical students to graduate physicians, from nurses to community health workers.***

   Essential to mental health programs is a small cadre of well-trained mental health professionals: psychiatrists, psychologists, social workers and psychiatric nurses. They are the ones who must lead efforts to establish priorities of mental health in medical education and health policy. Training primary care physicians, nurses and health workers in the recognition and appropriate referral and/or treatment of mental illness is central to expanding community services to meet needs. Specific training in diagnosis and management of psychiatric conditions is required to improve the quality of mental health services offered in primary care. And since community practitioners often depend almost exclusively on agents of pharmaceutical companies for new information on medications, initiatives in continuing education are needed to provide more basic training in the safe and effective use of psychotropic medications.

With appropriate training and supervision, nonphysician primary health workers can learn to diagnose, treat, and organize follow-up programs for a substantial fraction of cases of depression, anxiety and epilepsy, and can, with appropriate supervision, manage patients with chronic schizophrenia in the community if their social welfare is provided. WHO has developed training programs and shown they can be effectively employed in societies as diverse as India, the Philippines, and Tanzania. In societies in which nonphysicians provide a substantial portion of primary care, specialized training activities are a cost-effective means of improving and extending mental health services. Mainstreaming a gender perspective may build on the interests of many women professionals who have entered the field of mental health care as psychiatrists, psychiatric nurses, counsellors and social workers.

3. ***Promote efforts to improve state gender policies, toward interdicting violence against women, and toward empowering women economically, and to make women central in policy planning and implementation of mental health services. Research should evaluate the mental health consequences of these programs for women, for children, and for men.***
   As we have noted above, investing in the health, education, and well-being of women is of high priority for improving the mental health of populations in low and middle income countries. The World Bank's 1993 World Development Report clearly demonstrates that educating women to primary school level is the single most important determinant of both their own and their children's health. World Mental Health (1995) indicates women's education is an equally valuable investment for the mental health of women, men and children. Such education also renders women less likely to tolerate domestic violence and abuse, or the spending of substantial portions of the family income on drinking or gambling by their spouses. Educated women are also more likely to be receptive to and engaged, as equal partners, in public health programs.

   Women throughout the world constitute the vast majority of caretakers of first and last resort for chronically disabled family members, including mentally retarded children, demented elderly, and adults suffering a major mental illness. Minimally, it is in a community's long-term social interest to assist with this burden through formal health services. In addition, because women are critical to the success of health policies, their participation in formulating mental health policies should be encouraged, with governments, international organizations and NGOs defining avenues for women to exercise leadership roles. Policies may be evaluated by women's groups not only in terms of how they support women's mental health but also in terms of the quality of services offered to women, children and men.

4. ***Encourage initiatives to attend to the causes and consequences of collective and interpersonal violence.***
   Collective and interpersonal violence is one of the most pressing problems in the world today. Wars, prolonged conflicts, ethnic strife, and political repression lead to deep trauma and psychological problems that persist beyond the period of conflict and violence. While

only profound changes in international and national politics will reduce armed conflicts, peace and security initiatives should be strongly encouraged. In addition, mental health concerns should be more widely understood in peace and security programs. For ethnic conflict, for instance, mental health issues from the effect of racism on ethnic identity to the vicious cycles of revenge should become the target of new policies, such as education in schools. Transnational initiatives to treat trauma may assist in modest but effective ways as well to quickly respond to and aid victims of collective violence. Intervention programs of therapy and triage, which have been shown to have beneficial effects, need to be supported internationally as well as locally given costs and limited services in many parts of the world. Women's organizations have taken major roles in leading such efforts in the past and can be models for future efforts as well.

Curtailing and preventing interpersonal and domestic violence (often generated by community violence and breakdown) requires the mainstreaming of a gender perspective to formulate policies both in health care services and in the legal system. Although medical care for physical wounds and mental health care for psychological wounds may mitigate long term suffering, deterrence and ultimately prevention require laws that make domestic violence against women (and children) a crime.

5. ***Direct efforts specific to primary prevention of mental disorders and behavioral, psychosocial and neurological disorders.***

   Such efforts would survey the scientific knowledge base, examine primary prevention activities around the world, address the cross-cultural relevance of prevention programs, and define training needs and related activities. Successful prevention programs call for the integration of biological and psychosocial factors, and the active promotion of proven preventive programs. Models taking account of the co-morbidity of many disorders, the clusters of psychiatric disorders and psychosocial distress, must be developed in order to encourage interventions to support individuals who are afflicted with mental illness. In addition, prevention programs require an understanding of indigenous protective factors, such as the activities of caretakers of those who are ill and those local practices that enhance the mental and physical health and well-being of individuals and of communities. Listening to women, professional and lay, should help in identifying these factors.

***Acknowledgments***

The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Aruffo, J. F., Coverdale, J. H., & Chacko, R. C. (1990). Knowledge about AIDS among women psychiatric outpatients. *Hospital and Community Psychiatry*, 41, 326–328.

Australian Bureau of Statistics. (2006). *Mental Health in Australia: A Snapshot*, 2004-05, Australian Bureau of Statistics, Canberra.

Australian Institute of Health and Welfare. (2008). *Mental Health Services in Australia*, 2005-2006, Annual Report, p.16.

Cooper, H., Arber, S., & Fee, I., (1999) *The Influence of Social Support and Social Capital on Health.* London: Health Education Authority.

Coverdale, J. H., Turbott, S. H. & Roberts, H. (1997) Family planning needs and STD risk behaviours of female psychiatric out-patients. *British Journal of Psychiatry*, 171, 69–72.

Desjarlais, R., Kleinman, A., Eisenberg, L., & Good, B. (1995). *World Mental Health: Problems, Priorities, and Responses in Low-Income Countries.* Oxford University Press.

Gomm, R. (1996). *Mental health and inequality*. In Mental Health Matters (eds T. Heller, J. Reynolds, R. Gomm), pp. 110–120. Buckingham: Open University Press.

Guggisberg, M. (2006). The interconnectedness and causes of female suicidal ideation with domestic violence, *Australian Journal for the Advancement of Mental Health* (AeJAMH), 5(1), accessed at http://www.auseinet.com/journal/vol5iss1/index.php on 7th August, 2008.

Helson, R & Srivastava, S. (2001). Three paths of adult development: conservers seekers and achievers. *Journal of Personality and Social Psychology*. 80, 995-10 I0

Hoghughi, M. (1998). The importance of parenting in child health. Doctors as well as governments should do more to support parents (editorial). *British Medical Journal*, 316, 1545.

Keyes,C. L.M., Shmotkin, D. & Ryff, C. D. (2002). Optimising well-being: The empirical encounter of two traditions. *Journal of Personality and Social Psychology*, 82, 1007-1022.

Liverpool School of Tropical Medicine. (1998). *Guidelines for the analysis of gender and health.* http://www.liv.ac.uk/lstm/GG-1.html

Mezey, G. & Stanko, E. (1996). *Women and violence. In Planning Community Mental Health Services for Women.* A Multiprofessional Handbook (eds K. Abel, M. Buszewicz, S. Davison, et al), pp. 160–175. London: Routledge.

Mullen, P. E., Martin, J. L., & Anderson, J. C. (1994). The effect of child sexual abuse on social, interpersonal and sexual function in adult life. British Journal of Psychiatry, 165, 35–47.

Nicholson, J., Geller, J. L., & Fisher, W. H. (1993). State policies and programs that address the needs of mentally ill mothers in the public sector. *Hospital and Community Psychiatry*, 44, 484–489.

Nussbam, M. (2000). *Women and Human Development.* New York: Cambridge University Press.

Pollock, L. & West, E. (1987). *Women and psychiatry today*. Senior Nurse, 6, 11–14.

Pound, A. & Abel, K. (1996). *Motherhood and mental illness. In Planning Community Mental Health Services for Women*. A Multiprofessional Handbook (eds K. Abel, M. Buszewicz, S. Davison ), pp. 20–35. London: Routledge.

Procidano, M. E. & Helier, K. (1983). Measures of perceived social support from friends and from family: Three validation studies. *American Journal of Community Psychology*, II (I). 1- 22.

Roberts, G. L., Williams, G. M., & Lawrence, J. M. (1998). Women and Health, 28, 117–129.

Russo, N.F. (1990). Overview: forging research priorities for women's health. *American Psychologist.* 45, 368-373.

Ryff, C. D. & Keyes, C. L. M. (1995). The structure of psychological well- being revisited. *Journal of Personality and Social Psychology*, 69(4), 719- 72 7.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning Of psychological well-being. *Journal of Personality and Social Psychology*, 57, 1069-1081.

Standing, H. (1997). Gender and equity in health sector reform programmes: a review. *Health Policy and Planning*, 12,1–18.

Taft, A. (2003). Promoting Women's Mental Health: The Challenges of Intimate/Domestic Violence against Women. *Australian Domestic Violence Clearinghouse, Issues* Paper, 6, 2003.

Thara, R, & Srinivasan, T.N. (2000). How stigmatising is schizophrenia in India? *International Journal of Social Psychiatry*. 46(2), 135-41.

Thara, R. & Srinivasan, L. (1998). Management of social disabilities in schizophrenic. *Indian Journal of Psychiatry*, 40(4), 331-337.

Thara, R. (2004). *The mental health of women: years of neglect and a ray of hope*, In Agarwaal, S.P., Goel, D.S., Ichhpujani, R.L., Salhan, R.N., Shrivatsava, S. Mental Health- An Indian perspective (1946-2003), Directorate General of Health Services, Ministry of Health and Family Welfare, New Delhi. Pages, 233-239.

WHO. (1986).*The Ottawa Charter for Health Promotion*. First International Conference on Health Promotion, Ottawa, 21 November 1986.

WHO. (2000). *Women's mental health: an evidence based review*, Geneva, World Health Organization: WHO/MSD/MHP/00.1.

WHO. (2008). *Gender and women's mental health: gender disparities and mental health*: The Facts, accessed at http://www.who.int/mental_health/prevention/genderwomen/en/ on 1st August 2008.

World Bank. (1993). *World Development Report 1993: Investing in Health*. New York: Oxford University Press.

World Health Organization [WHO]. (1995). Problems and priorities in low-income countries. *The New England Journal of Medicine: Research and review*, 5, 333, 1227-1228.

**How to cite this article:** Ashwini R, Prasad V (2017), Women Mental Health and Well-being: A New Paradigm, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.102/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.103/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Well-Being of Adult and Aged Women Facing Interpersonal Violence: A Study of Women Living In Shimla District of Himachal Pradesh

Dr. Meera Manjul[1]*

**ABSTRACT**

This study attempted to investigate the direction and magnitude of the relationship of well-being with intrapersonal violence in reference to the adult and aged women facing interpersonal violence. More specifically, it has been tried to see the difference between adults and aged women on these variables i.e. well-being and interpersonal violence and to investigate the influence well being on interpersonal violence among these two strata of women. The total sample N=400, adult (n=200), aged (n=200) was given general well being scale Verma & Amita and interpersonal violence scale of Edleson and Minnesota. Besides, correlation, regression and t-test were performed. The findings revealed that well being is significantly and negatively correlated with interpersonal violence among adult and aged women. Aged women were higher on well being as compared to adult women. Adult women were higher on interpersonal violence as compared to aged women. It may also be said that well being emerged as a predictor of interpersonal violence among aged women.

***Keywords:*** *Interpersonal Violence, Well-Being, Women*

**W**ell-being is generally defined as the subjective feeling of contentment, happiness, satisfaction, sense of achievement, utility and belongingness etc. Emmons (1992) has found that level of personal striving is closely related to well-being and satisfaction is related to well-being. This is also positively associated with contentment and this tends to differ life events of a person. Beyond this, it is considered to have positive correlation with quality of life, satisfaction level in job as well as in general life, sense of achievement and overall personality development. Simultaneously, this is considered negatively related with neuroticism, psychoticism, and other such factors that contribute to enhance negativity in life. It is also well established that it depends

[1] Co-ordinator, Youth Development Centre, HPU & Faculty Member, Life Long Learning Department, HP University, Shimla, Himachal Pradesh, India
*Responding Author

**Received: January 27, 2017; Revision Received: February 16, 2017; Accepted: February 24, 2017**

on a network of relationship with other variables i.e. the variations in the other variables may tend to affect the well-being of a person. Like living status is important part of life, the personality traits also matters, that is what they feel, like or dislike, satisfaction, experience of work, belongingness, utility etc. Violence in general and interpersonal violence tends to have close association with the well-being a person (Bacchus et al, 2006; Mattila et al, 2006). In the present times of globalisation, voices against interpersonal violence against women are coming from every part of the world and interpersonal violence is the most reported form of violence (Okemgbo, 2002; Horne, 1999; Mcwhirter, 1999).

Given to women's stressful living conditions inside their homes, the health, and human right concerns of women are of vital importance and deserves to be given serious attention. Their vulnerability to violence expands and the probability of violent events increases when they work outside their homes, outside their familial and social boundaries. Bacchus et al (2006) did a qualitative study of 16 women who had experienced domestic violence in the previous 12 months. The violence was perpetrated by a current or former partner in all but one case. Ten of the 16 women had experienced domestic violence during their recent pregnancy, of which four women had also been assaulted in at least one previous pregnancy. Three women had been assaulted by their partners in a previous pregnancy but not during their recent pregnancy, and three had experienced domestic violence outside of pregnancy only. Some women reported increased feelings of insecurity, jealousy, and possessiveness in their partner during their pregnancy. Abuse within the relationship centered around the arrival and care of the new baby; financial worries, the woman's lessening physical and emotional availability during pregnancy, the lack of practical and emotional support from the male partner, and doubts about paternity. Mattila et al (2006) conducted a study on risk factors for violence and violence-related injuries among a random sample of 14 to 18 year-old finns (3319 boys, 3890 girls) were sent a questionnaire on the occurrence of violence and violence related injury. Altogether, 76% responded. Weekly stress symptoms, depressive mood, smoking, drunkenness, peer drug use, previous unintentional injury and not living with both parents predicted both incidents.

Henton et al (1983) in their study have established a correlation between dating violence and well being. Their results showed that in the sample 60.3% felt angry, 57.5% felt hurt, surprised or sorry was the feeling of 34.2%. 31.5% were scared. Bohan (1997) reported that sexually abused women ranked personal values such as inner harmony, self-respect, wisdom and health as most important to them. The non-abused women ranked the outer values of equality, a world of peace, national security, and world of beauty as most important which may indicate greater psychological maturity. Mean scores for anxiety and conflicts in 15 women who reported childhood sexual abuse were significantly higher than those for 15 women who had experienced no abuse. The majority of the sexually abused reported feeling only a moderate amount of wellbeing.

Loxton et al (2006) examined the psychological health correlates of domestic violence in a large random sample of mid-aged Australian women (age 47 to 52 years). Logistic regressions were used to investigate the associations between domestic violence and depression, anxiety, psychological well-being, after adjusting for demographic variables (marital status, income management). The results indicate that a history of domestic violence is associated with decreased psychological well-being. Balsam and Dawn (2005) conducted a study on relationship quality and domestic violence in women's same-sex relationships. Degree of loudness, internalized homophobia, lifetime and recent experiences of discrimination, butch/femme identity, relationship quality and lifetime and recent experiences of domestic violence were assessed in a sample of 272 predominantly European American lesbian and bisexual women. In bivariate analyses, minority stress variables (internalized homophobia and discrimination) were associated with lower relationship quality and both domestic violence perpetration and victimization. Analysis revealed that relationship quality fully mediated the relationship between revealed that relationship quality fully mediated the relationship between internalized homophobia and recent domestic violence.

Interpersonal violence against violence is primarily associated with intimate relationship which a woman leads. It is argued that interpersonal violence constitutes physical violence, sexual violence, threats of such violence, and emotional abuses etc. Her intimate partners cause physical, psychological or sexual harm for the known or unknown reasons. Sometimes such women became victim of the caprice of the partner and the other time their own weakness for not responding back led them into such a situation leading to violence against them. In such a situation the status of well being tend to be cause of interpersonal violence against women. It is not disputed that women face interpersonal violence irrespective of their age and social status simply because they are women.

The young generation of women is more educated, aware, knowledgeable and confident about their existence as compared to the women in the middle and older age group. Therefore, it has been argued that violence is more directed towards adult and aged women but most of studies on violence are centred on married and unmarried, working and non-working women. The area constituted by the adult and aged women is relatively less explored. There is dearth of data concerning the interpersonal violence against adult and aged women. This group constitute the women who share the family and social responsibility to greater degree. Therefore, this study is a humble attempt to assess well being of women facing interpersonal violence.

General well-being may be defined as the subjective feeling of contentment, happiness, satisfaction with life's experiences and of one's role in the world of work sense of achievement, no distress, dissatisfaction or worry. It is a dynamic state characterised by a reasonable harmony between an individual's abilities, needs and expectations, and environmental demands and

opportunities (Levi, 1987). It is also considered to be connotative of a harmonious satisfaction of one's desire and also involves individual pleasure depending upon his psychological status and environmental conditions.

The concept of well-being is seen as an abstraction and different connotations. While utilitarianism see well-being as well-feeling i.e. pleasure seeking, and from the economic point of view it is reflected by income and in the words of Fromm (1978) it is reduced to being well-off materially and financially. Thus, it may be said that well-being subsume quantity of life as well as quality of life (Ryan & Deci, 2001). It can be summarised that material well-being; happiness, health, and overall participation in society in society are correlated. Dasgupta (2001) calculates that in many low-income countries the rise in present wellbeing has been achieved by degradation of natural assets and the societal wealth of well-being over time has fallen. Given the many relevant aspects of well-being, there are many major aspects of 'objective' well-being such as health, family life, employment, recreation, quality of death, and these are also major determinants of subjective well-being.

With well-being of individual violence shares close association as this has detrimental effect on the well-being of the victim (McCauley et al, 1995). Devries et al (2011) have found that violence against women is strongly associated with suicide attempts. Summarily, it affects significantly not only its victims as individuals but the society as a whole (Martin et al,2000; Commons,2000).Despite the increasing recognition that violence against women is a global public health concern, population based studies of violence against women and its determining consequences remain scarce in developing countries (Gage,2005). There is much that remains to be understood about the total set of possible association of violence against women with reference to their well being.

## METHODOLOGY

Having the primary aim of investigating the direction and magnitude of the relationship of well-being with interpersonal violence in reference to the adult and aged women facing interpersonal violence, this study also attempted to explain the difference on variables of well-being and interpersonal violence. This study has been carried out in the Shimla city of Himachal Pradesh which is also capital of State. The total population of Himachal Pradesh is 60,70,305 (Census, 2011) out of which nearly 50% of which are females and the cases of domestic and interpersonal violence have been regularly reported in this State. Correlational design was used to study the interpersonal violence and well being among adult and aged women. Further, data has also been subjected to t-test and regression analysis. Total 400 women (N=200 adult women+ N=200 aged women) constitute sample of the study. In order to observe prevalence and nature of violence faced by the participants a brief interview was also conducted besides, the tools were used to assess the interpersonal violence and well-being of the adult and aged women as followed:

1. ***Interpersonal violence scale****:* For assessing interpersonal violence among the women in sample, an Interpersonal Violence Scale was developed to explore the interpersonal violence among the adult and aged women following the lines of Edleson& Minnesota (2007) scale on domestic violence. For assessing violence exposure to women, 33 items on five point scale inventory were constituted. There were five options: Never, sometime, often, almost and always. Each item is scaled from the lowest to the highest and each sub-item representing a point on the scale. This also means that only one of the sub-items is to be checked for a particular respondent under each of the 33 items. The score on each item ranges from 1 to 5. To get the total interpersonal violence score is calculated by, adding all the factors score. Total score ranges from 33 to 165 and higher score indicate more interpersonal violence.
2. ***General well-being (Verma and Amita, 1989)***: There are 20 items in this scale. Observations of any unusual nature, restlessness, physical discomfort due to any reason, being in a hurry, a significant even in resent past like death in the family, accident, examination/interview, fatigue, disinterest, etc. have been taken note of and considered while interpreting test results, on the usual lines of a clinical interview. The reliability of the scale is .86.

***Scoring***

Numbers of ticks are counted and constitute the well-being score of that particular individual at the time. Firstly, the human resource women were requested to arrange interaction session with the adult and aged women respectively. In this session the participants were given a brief overview of the concepts of violence and well being.

After getting the list of participants who were randomly selected on the basis of age and education and who have given their consent to participate in the study, were contacted individually by the investigator and were assured that the information given by them would be kept confidential. The standard instruction with reference to each scale was administered to each participant. After establishing a good rapport with the subjects, the tester ought to read instructions, while subjects do read them silently along with her. The subjects are asked to respond any one alternative of each item by marking a tick. They were again assured that the data so collected should only be used for academic purpose. After collecting all the questionnaires, scoring was done as per the instruction given in the scoring manuals of each variable of violence, well being following test were applied to the data obtained:

## RESULTS AND DISCUSSION

The results of the present study indicate that well being is negatively and significantly correlated with interpersonal violence in whole sample among adult and aged women. Further, the results show that the significant difference among adult and aged women in whole sample on these

variables i.e. well being and interpersonal violence. Further, the score of well being of aged women is higher than adult women. So it is clear that the score of interpersonal violence in case of adult is higher than aged women in whole sample.

The scores of adult women are also significantly and negatively correlated between well-being and interpersonal violence (r=-.32**, p<.01). The scores of aged women are also significantly and negatively correlated between well being and interpersonal violence (r=-.51**, p<.01).

The findings do find support from the earlier studies done in this area. Henton et al (1983) in their study have established a correlation between dating violence and well being. Their results showed that in the sample 60.3% felt angry, 57.5% felt hurt, surprised or sorry was the feeling of 34.2%. 31.5% were scared. Bohan (1997) reported that mean scores for anxiety and conflicts in 15 women who reported sexual abuse were significantly higher than those for 15 women who had experienced no abuse. The majority of the sexually abused women reported feeling only a moderate amount of wellbeing. Loxton et al (2006) found that current psychological well-being had an inverse association with a history of domestic violence: as psychological well-being decreased, the odds of having ever experienced domestic violence increased.

Going beyond, the second objective of the study was to investigate the differences in adult and aged women on the variables viz. interpersonal violence and well being so t- test was applied to know the same. The result of the t-test analysis showed the significant differences between adult and aged women on their scores of well being (t=-12.94,p<.01) and the mean scores of adult women is lesser than the mean scores of aged women on their scores of well being (M(ad.)=10.38/ M(ag.) =14.03).The significant differences have also emerged between adult and aged women on their scores of interpersonal violence (t=9.43,p<.01) and the mean score of adult women is higher than the mean score aged women on their scores of interpersonal violence(M(ad.)=70.01/ M(ag.) =57.78). Results have revealed significant difference between adult and aged women in terms of interpersonal violence. The mean values of adult women on interpersonal violence were higher as compared to aged women. This indicates that the interpersonal violence among adult women is in higher as compared to aged women.

It is clear that the aged women have better well being as compared to adult women. Because they have no choice for betterment, their children are married or old, so their needs are very short in nature. So they have no more choices, most of them are widow, divorcee, and single stage. They have lost their husbands due to some family circumstances, or internal circumstances they don't want anything more in their lives. Most probably they are fully satisfied, and get better well being than adult women because they realize every incident but have capacity to face the situation related them, as compared to adult women.

Having said this, the major findings of the study are- (i) well being is significantly and negatively correlated with interpersonal violence among adult and aged women, (ii) aged women were higher on well being as compared to adult women, and (iii) adult women were higher on interpersonal violence as compared to aged women.

These findings are in consistent with the findings of Philips et al (2005) who have found a substantial relationship between aging and well being as they tend to use inward focused strategies to sooth or calm the conflict. The findings also corroborated with the findings of Carstense et al (2003) that in older people high level of well being is due to good regulations of emotions. Gross etal ((1997) and Della Sala (2002) too have indicated the similar trends.

***Acknowledgments***
The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Bacchus, Loraine; Mezey, Gill; Bewley, Susan (2006) "A qualitative Study of 16 women who had experienced domestic violence in the previous 12 months." *Violence against Women*. Vol. 12(6) 588-604.

Balsam K.F., and Szymanski, Dawn M.(2005), "Relationship Quality and domestic violence in women's same-sex relationship: The role of minority stress." *Psychology of Women Quarterly* Vol. 29(3) 258-269.

Bohan, M. J. (1997) "Assessing adult women sexually abused in childhood for anxieties, conflicts, and values: A Bio-psychosocial approach to well-being", *Dissertation Abstracts International* 57(7-B), 4694.

Carstense, I.L., Fung, H.H., Charles, S.T. (2003), "Socio-emotional selectivity theory and the regulation of emotion in the second half of life" *Motivation and Emotion*, Vol. 27(1), 103-23.

Commons, Mandy; Deello, Lesley R. (2000), "The Effect of parental Divorce and Remarriage and the Experience of Familial Conflict on Young Adult Offspring Adjustment". *Journal of Research and Applications in Clinical Psychology*. Vol.3(1), 11-

Dasgupta, Partha (2001), Human Well-being and the Natural Environment. Oxford Univ. Press.

Della Sala, S., Macpherson, S.E., Philips, L.H., (2002), "Age executive function, and social decision making: A dorsolateral prefrontal theory of cognitive aging." *Psychology and Aging.* Vol.17(20), 598-609.

Devries k, Watts C, heise L, Schraiber LB, and jansen H. (2011), "Violence against women is strongly WHO multi-country study on Women's health and domestic violence against women". *Social Sciences and medicine* Vol. 73(1), 79-86.

Edelson, L. J.; Minnesota, St. Paul (2007), *Children exposure to domestic scale*.

Emmons, R. A. (1992), "Abstract versus concrete goals; personal striving level, physical illness, and psychological well-being". *Journal of Personality and Social Psychology*. Vol. 62 (2), 292-300.

Fromm, Eric, (1978), To have Or To Be. London: Jonathan Cape.

Gage, A.J., (2005), "Women's experience of intimate partner is Gaibi" *Soc.Sci.Med*. Vol.61,343-364.

Gasper, Des (2002), "Is Sen's Capability Approach an Adequate Basis for Considering Human Development?" *Review of Political Economy* 14(4), 435-461.

Gross, J.J. Carstensen, L.L., Pasupathi, M., Tsai, J., Skorpen, C.G., Hsu, A.Y.C. (1997). "Emotion and aging: experience, expression, and control." *Psychology and Aging* Vol.12, 590-599.

Henton, J. Cate, R.Koval, J., Lloyd. S. Christopher, S. (1983), "Romance and violence in dating relationships." *Journal of Family Violence.* New York. APA Books.

Horne, S. (1999), "Domestic Violence in Russia." American Psychologist, Vol. 54, 55-61. http/www.moncava.umn.edu/cedv.

Levi, L. (1987), *"Fitting work to human capacities and needs"* in Katme (Eds.), Improvement in contents and organization of work: Psychological Factors at work. New York: Saunders Co.

Liu, B.C. (1976), *Quality of life indicators in USA metropolitan area: A statistical analysis.* New York: Prayer Publishers.

Loxton, Deborah; Schofield, Margot; Hussain, Rafat (2006), Psychological health in midlife among women, who have ever lived with a violence partner or spouse. *Journal of Interpersonal Violence* Vol. 21(8), 1092-1107.

Martin Sandra L. Kathryn E. Moracco, Julian Garro, Amy Ong Tsui, Lawrence L. Kupper, Jennifer L. Chase, Jacquelyn C. Campbell (2000), "*Domestic violence across generations"* http://ije.oxfordjournals.org/cgi/content/abstract

Mattila, Vile M. Parkkari, Jari P.; Rimpeli, Arjati. (2006), "A Study on Risk Factors for Violence and Violence-related injuries." *Journal of Adolescent Health* Vol. 38(5), 617-20.

McCauley J, kem D. E.; Kolodner K, Dill L., Schroeder A. F., DcChant H. K., (1995), "The battering syndrome prevalence and clinical characteristics of domestic violence in primary care internal medicine practices*." Ann Item Med* Vol.123(10), 737-46.

McWhirter, P. T,. (1999), "Domestic Violence in Chile." *American Psychologist*, Vol.54, 40-47.

Okemgbo C. N., OmideyiA.k., Odimegwu C. O. (2002), "Prevalence patterns and correlates of domestic violence in selected lgbo communities in Imo State, Nigeria" *Afr. J. Reprod. Health Surv*. 38-53.

Philiphs L.H., Henery J.D., hosiej.A., and & Milne A.B. (2005), "Age, anger regulation and well-being". *Aging and Mental health* 10(3),250-56.

*Situational Analysis of Women and Girls in Himachal Pradesh* (2004). New Delhi: National commission for Women.

Verma, S. K.; Verma, Amita (1998), PGI General Well-being Scale. *Ankur Psychological Agency*, Lucknow.

**How to cite this article:** Manjul M (2017), Well-Being of Adult and Aged Women Facing Interpersonal Violence: A Study of Women Living In Shimla District of Himachal Pradesh, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.103/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.104/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Psychological Study of the Persons Suffering From Sickle Cell Disease in Raigarh District of Chhattisgarh State

Dr. Rajesh Kumar Ajagallay[1]*, Dr. Gaukaran Janghel[2], Dr. Vimal Chandra Bhagat[3], Viyata Chanda[4], Dr. Rakesh Kumar Agrawal[5], Dr. Neelam Naik[6]

## ABSTRACT

***Background:*** Sickle cell disease is an inherited blood disorder in which the body produces abnormal shaped red blood cells (RBC). The disease affects both biological and psychosocial aspects of patients. ***Aim:*** Present study aimed at investigating the different mental health dimensions used by heterozygous and homozygous sickle cell anemic patients. ***Method:*** The cross-sectional study design with the total 100 sickle cell anemic adolescents of both the sexes were selected in 10 to 20 year age groups, from various hospitals and health clinics of Chhattisgarh, India. The correlation analysis was used for analyzing the data. ***Results:*** Total 100 patients were selected which consisted of 30 homozygous and 70 heterozygous adolescent patients with sickle cell gene. The Emotional Stability was which higher significantly correlated with the intelligence quotients, IQ ($r = .387$, $p < .001$) than the other dimensions. Only two dimensions of mental health viz. emotional stability (t- 2.38; $p<.018$) and self-concept (t- 2.32; $p<.001$) of sickle cell patients which differed among heterozygous and homozygous patients.

***Keywords:*** *Sickle Cell Disease, Mental Health Dimensions*

Sickle cell disease is an inherited blood disorder in which the bone marrow produces abnormal shaped red blood cells. These cells become stiff and C-shaped and the hemoglobin clumps together. These sickle cells block blood and oxygen flow in blood vessels and these cells break down more rapidly than normal red blood cells, which results in severe anaemia.

[1] MD. Psychiatry, Associate Professor, Lakhiram Agrawal Memorial Govt. Medical College, Raigarh, CG, India
[2] Ph. D Psychology, Clinical psychologist, Lakhiram Agrawal Memorial Govt. Medical College, Raigarh, CG, India
[3] MD Psychiatry (Assistant Professor, Lakhiram Agrawal Memorial Govt. Medical College, Raigarh, CG, India
[4] M. Phil Psychology, Clinical Psychologist, Lakhiram Agrawal Memorial Govt. Medical College, Raigarh, CG, India
[5] MBBS, Lakhiram Agrawal Memorial Govt. Medical College, Raigarh, CG, India
[6] MBBS, Lakhiram Agrawal Memorial Govt. Medical College, Raigarh, CG, India
*Responding Author

**Received: January 25, 2017; Revision Received: February 16, 2017; Accepted: February 24, 2017**

Sickle cell disease (SCD) is the most common genetic hemoglobin disorder, affecting more than 70,000 Americans, primarily those of African and Mediterranean origins. The disease is characterized by chronic hemolytic anaemia, vaso-occlusive complications, and increased risk of infection with associated shortened lifespan up to 30 years (Plott, et al.1994).

The mental imbalance is one of the most important problems for persons with sickle cell disease which may be due to continued panic condition. The sickle cell disease is an autosomal recessive genetic disorder and also the most common hemoglobinopathy. The homozygous sickle cell anemia, HbSS is a more severe form of sickle cell disease than sickle cell trait, HbAS (Levenson, et al. 2008). Sickle cell disease shows in two major forms: sickle cell beta thalassemia (Sβ0 and Sβ+) and sickle cell hemoglobin- C (SC) (Levenson, et al. 2008).

Kornhauser defined the mental health in 1965 as "those behaviors, perceptions, and feelings which determine the overall level of personal effectiveness, success, happiness, and excellence of functioning as a person". The concept of mental health takes a "Gestalt" view of the individual with which it incorporates the overall personality characteristics and behavior of the individual (Sing & Sengupta, 1983). A homogeneous organization of desirable attitudes, healthy values and right self-concept, a scientific perception of the world were shown by a mentally healthy person (Erickson, 1993; Hurlock, 1972). Morgan and Jackson, 1986 conducted a study and found that adolescents with sickle cell anemia reported less satisfaction with their bodies, more symptoms of depression and spend less time in social and unsocial activities (Morgan & Jackson, 1998). Earlier studies have been done with an aim to determine the prevalence of psychiatric disorders among sickle cell adolescents and it was observed that a high prevalence of psychiatric disorders including depression, anxiety, attention-deficit/ hyperactivity disorder, oppositional defiant disorder, and conduct disorder (Benton, Boyd, Ifeagwu & Smith-Whifley, 2011).

Witmer & Sweeny, 1992; Hattie, Myers & Sweeny (2004), stated that a mental well-being and mental health are holistic concepts consisting of anthropological, sociological, educational, psychological and religious perspectives as well as theoretical perspectives from personality, social, clinical, health and developmental psychology. The present study evaluates mental health by six dimensions viz. Emotional Stability, Overall Adjustment, Autonomy, Security-Insecurity, Self-Concept and Intelligence of patients with sickle cell disease and their relationship to each other.

***Objectives of the research-***

1. To explore the mental health of Heterozygous and homozygous sickle cell anemic patients.

***Research design***

The cross-sectional study design and purposive sampling technique was used in the current research.

## METHODOLOGY

***Inclusion criteria for participants***

Those persons who were already medically diagnosed with sickle cell anemia by sickle cell unit and pathology in LAMGMC, Raigarh, India and who gave consent were included in the study.

***Target group***

The target group of the present study was person suffering from sickle cell anemia in Raigarh district of Chhattisgarh state.

***Size of sample***

Total 100 adolescents with sickle cell anemia of both sexes were selected purposively from 10 to 20 year of age group, from LAMGMC, Raigarh, Chhattisgarh, India. These participants were clinically diagnosed as homozygous and heterozygous sickle cell anemia by sickle cell unit and pathological laboratory.

***Measures***

**Mental Health Battery (MHB- Singh & Sengupta, 1983)**

The *Mental Health Battery* (MHB), basically developed by Sing & Sengupta (1983) was opted for the present investigation. The mental health battery was using for measurement of mental health dimension in sickle cell anemic persons. The MHB measure used six popular mental health dimensions of a person, viz. Emotional Stability (ES), Overall Adjustment (OA), Autonomy (AU), Security-Insecurity (SI), Self-Concept (SC) and Intelligence (IQ). The MHB is a reliable and valid instrument for the measurement of mental health. Reliability of the present data showed that the coefficient of Alpha (α) is 0 .88.

***Statistical analysis***

The Obtained data was analyzed in the Pearson correlation analysis for the correlation of mental health dimension in homozygous and heterozygous sickle cell patients and t- test was applied for statistically significant differences between mental health dimension of Heterozygous and Homozygous patients.

## RESULT

Total 100 patients were selected out of which of 30 were homozygous and 70 were heterozygous adolescent patients with sickle cell gene.

The table no. 1 shows a correlation between different mental health dimensions in heterozygous sickle cell patients. It revealed that each dimension of mental health of heterozygous sickle cell patients highly correlated with other dimensions, as Emotional Stability was higher significantly correlated with the intelligence quotients, IQ (r = .387, p< .001) than the other dimensions, whereas Overall Adjustment was also positively correlated with the Self-concept (r = .447, p< .001), Autonomy was positively and highly correlated with Self-concept, SC (r = .345, p < .001) than the other dimensions, Security-insecurity also highly correlated with the self-concept (r = .433, p< .001) as compared to other dimensions.

***Table 1 shows the correlation of mental health dimension in heterozygous sickle cell patients***

| Correlation | ES | OA | AY | SI | SC | IQ | MHB TOTAL |
|---|---|---|---|---|---|---|---|
| ES | 1.000 | .299** | NS | .245** | .313** | .387** | **.644**** |
| OA | | 1.000 | .386** | .377** | .447** | .264** | .739** |
| AY | | | 1.000 | .254** | .345** | .188* | .510** |
| SI | | | | 1.000 | .433** | NS | .563** |
| SC | | | | | 1.000 | .194* | .634** |
| IQ | | | | | | 1.000 | .690** |
| MHB Total | | | | | | | 1.000 |

*(p< 0.05) **(p < 0.01)

The table no. 2 shows a correlation between dimensions of mental health among homozygous sickle cell patients. The table revealed that emotional stability (ES) was strongly correlated with the overall adjustment (OA) ( r =.697, p<.001), than the other dimensions, whereas overall adjustment, OA was highly correlated with dimension IQ ( r =.721, p<.001), than the other dimension, Autonomy(AY) was significantly correlated with the intelligence quotient(IQ)( r =.483, p<.001), than other dimensions. security insecurity (SI) was highly and positively correlated with Emotional stability (ES) (r =.298, p.001) while other dimension of mental health were not correlated with each other.

***Table 2 showing the correlation of mental health dimension in homozygous patients***

| Correlation | ES | OA | AY | SI | SC | IQ | MHB TOTAL |
|---|---|---|---|---|---|---|---|
| ES | 1.000 | .697** | NS | .298** | .478** | .670** | .865** |
| OA | | 1.000 | .465** | NS | NS | .721** | .868** |
| AY | | | 1.000 | NS | NS | .483** | .495** |
| SI | | | | 1.000 | NS | NS | NS |
| SC | | | | | 1.000 | .355* | .437* |
| IQ | | | | | | 1.000 | .904** |
| MHB Total | | | | | | | 1.000 |

* (p< 0.05) **(p < 0.01)

The table no. 3 shows mean, standard deviation, t-value, and two-tailed significance of heterozygous and homozygous patients with sickle cell gene. It revealed only two dimensions of mental health viz. emotional stability (t- 2.38; p<.018) and self concept (t- 3.32; p<.001) of sickle cell patients which differed among heterozygous and homozygous patients. The mean and SD value shows total mental health (75.4 ± 12.18) with Emotional Stability, Self Concept, Autonomy, Security insecurity, Overall Adjustment of heterozygous patients to be higher than total mental health score(71.80 ± 15.26) of homozygous patients.

***Table 3 showing the differences between mental health dimension of Heterozygous and Homozygous patients***

| SN | Mental Health dimensions | Zygosity | Mean | SD | t- Value | Significant |
|---|---|---|---|---|---|---|
| 1 | Emotional Stability | Heterozygous | 9.79 | 3.28 | 2.38 | **.018** |
| | | Homozygous | 8.43 | 3.25 | 2.39 | **.019** |
| 2 | Overall Adjustment | Heterozygous | 24.54 | 4.15 | 0.76 | .450 |
| | | Homozygous | 23.93 | 5.60 | 0.67 | .507 |
| 3 | Autonomy | Heterozygous | 10.84 | 2.01 | 1.33 | .184 |
| | | Homozygous | 10.37 | 2.00 | 1.34 | .185 |
| 4 | Security insecurity | Heterozygous | 9.58 | 2.10 | 1.62 | .106 |
| | | Homozygous | 8.98 | 2.17 | 1.60 | .113 |
| 5 | Self Concept | Heterozygous | 7.31 | 2.30 | 3.32 | **.001** |
| | | Homozygous | 6.02 | 2.04 | 3.50 | **.001** |
| 6 | Intelligence | Heterozygous | 13.38 | 4.83 | -0.76 | .446 |
| | | Homozygous | 14.07 | 5.89 | -0.70 | .485 |
| 7 | Total Mental Health Score | Heterozygous | 75.44 | 12.18 | 1.59 | .114 |
| | | Homozygous | 71.80 | 15.26 | 1.44 | .153 |

## DISCUSSION

The severity of Sickle cell disease is affected by hereditary and some environmental factors viz. mental health, socio-demographic etc. The present study aims to find out those factors which influence the mental status and physical condition of heterozygous and homozygous patients. Some studies have suggested that the sickle cell disease affected persons use different strategies for coping with the problems of sickling. Seigel, Golden, Gough (1990) assessed the association between depression, self-esteem, and life events in adolescents with asthma, sickle cell disease, and diabetes.

Schatz & Roberts (2005) examine that the short term memory span and working memory performance among the children with SCD (n=25) and demographically matched comparison children (n=25), and it was observed that the children with SCD had difficulties only for digit span- backward performance. Schatz, et al. (2002) identified auditory verbal measures, and which found the areas of deficit in Wechsler scale vocabulary, arithmetic digit span, subtest were significant in SCD. Similarly the numbers of studies have identified impairments in cognitive

function in children with SCD. Cognitive deficits have been noted in general intelligence ( Knight, Singhal Thomas, et al. 1995; Wasserman, Wiliams & Fairclough, et al. 1991), academic abilities such as reading (Wasserman, Wiliams & Fairclough, et al. 1991; Fowler, Whitt, & Lallinger, et al. 1988), writing, arithmetic (Wasserman, Wiliams & Fairclough, et al. 1991), spelling (Fowler, Whitt, & Lallinger, et al. 1988), attention (Sano, Haggerty & Kugler, et al. 1996), Visio spatial (Wasserman, Wiliams & Fairclough, et al. 1991; Sano, Haggerty & Kugler, et al. 1996), and memory (Wasserman, Wiliams & Fairclough, et al. 1991), general intelligence (Armstrong, Thompson & Wang, et al.1996; Hairman, Griffith & Hurtige, et al. 1991), and academic abilities such as arithmetic and language (Armstrong, Thompson & Wang, et al.1996). Bennett (1994) showed that children with SCD were at increased risk factor for depressive symptoms.

Number of studies has been conducted to specifically examine the behavior problem of children and adolescent with SCD, and the finding have indicated an increased frequency of behavioural or psychological problems (Whitte & Debaum, 1998).

They examined 80 adolescents with age range of 12 to 18 years and compared to a group of 100 demographically matched peers. Both groups completed the BDI, Rosenberg Scale of Self-Esteem, and the McCutcheon Life Events Checklist. They found that the mean depression scores were significantly higher in the chronic disease groups compared to healthy peers and the illness groups were more likely to have low self-esteem. However similar study no differences were found illness groups in depression, self-esteem or life events (Seigal, Golden, Gough, Lashley, & Sacher, 1990). Few other studies revealed that the most frequent psychological problems encountered were anxiety, depression, social withdrawal, aggression, poor relationships and school performance (Evans, Burlew & Ofer, 1988; Brown, Armstrong & Eckman, 1993). Some case reports also indicated high levels of parental anxiety, overprotection, guilt and excessive feelings of responsibility (Graham, Reed, Levit, Fine & Medalie, 1982; Whitten & Fischoff, 1974).

Noll et al. (1996) found that males with sickle cell disease are less aggressive whereas females with SCD are less sociable and less well-adjusted than the peer groups. The common complications of sickle cell disease including chronic fatigue and small physical size, chronic pain and stigma related to illness may explain these behaviors. There are also significant problems in adjustment particularly for adolescents with sickle cell disease, and most significantly in the areas of behavior and social adjustment ( Hurtig et al. 1986). Seigel, Golden, Gough (1990) found that the mean depression scores were significantly higher in the illness group and more likely to have low self-esteem compared to healthy peers. They concluded that the most frequent psychological problems encountered are anxiety, depression, social withdrawal, aggression, poor relationships and poor scholastic performance. Both children and

adults with Sickle cell disease suffer from neurocognitive impairments and psychological complications including inappropriate pain coping strategies; reduced quality of life owing to restrictions in daily functioning, anxiety, and depression (Anie, 2005).

Sickle cell disease has significant negative influences on IQ and cognitive functions. Consistent with these findings, our study revealed that two dimensions of mental health viz. emotional stability and self concept of sickle cell patients were significantly higher among heterozygous compared to homozygous patients. The total mental health with Emotional Stability, Self-Concept, Autonomy, Security insecurity, and Overall Adjustment of heterozygous patients are higher as compare to homozygous patients and could be attributed to Homozygous Sickle cell disease patients having more somatic problems compared to heterozygous and there is a significant positive relationship between Maladaptive coping style and somatic problems (Ogre, et al. 2016).

The mean values of IQ in sickle cell disease were 5.6 points lower than in normal healthy controls. The difference occurred in both verbal and performance subscales of the IQ score (Knight et al. 1995).

## CONCLUSION

There are limitations to this study. We used a cross-sectional study design, and thus, causal interpretations of the results cannot be established. It is possible that patients with more severe cases of Sickle cell disease would go to a higher center and thus, may be more informed about their disease. We have not included the normal healthy control in our /study; therefore we cannot compare it with the general population. Future research comparing mental health and attitudes toward sickle cell disease in other regions of Chhattisgarh would be beneficial to detect mental health problems and stigma related to illness which is most neglected part of this illness.

***Acknowledgement***

I would like to thank all the patients of sickle cell disease registered in the Late. Shree Lakhi Ram Agrawal Memorial Medical College (LAMGMC) Raigarh, Chhattisgarh, India.

***Conflict of Interest:*** The author(s) declare that they have no conflict of interests.

## REFERENCES

Anie, K. A. (2005). Psychological complications in sickle cell disease. *British journal of haematology*, 129(6), 723-729.

Armstrong, F. D., Lemanek, K. L., Pegelow, C. H., Gonzalez, J. C., & Martinez, A. (1993). Impact of lifestyle disruption on parent and child coping, knowledge, and parental discipline in children with sickle cell anaemia. *Children's Health Care*, 22: 189–203.

Armstrong, F. D., Thompson, R. J., Wong, W. et al. (1996). Cognitive function and brain imaging in children with sickle cell disease. *Journal of pediatric*, 97, 864-70.

Bennett, D. S. (1994). Depression among children with chronic medical problems: A meta-analysis. *Journal of Pediatric Psychology*, 19, 149-69.

Benton, T. D., Boyd, R., Ifeagwu, J., Feldtmose, E. & Smith-Whitley, K. (2011). Psychiatric Diagnosis in Adolescents with sickle cell Disease: A Preliminary Report. *Current Psychiatric Report*, 13: 111-115.

Brown, R. T., Armstrong, F. D. & Eckman, J. R. (1993). Neurocognitive aspects of sickle cell disease. *Journal of Learning Disabilities*, 26: 33–45.

Erickson, E. (1993). *Childhood and Society* (2nd ed.): New York, Norton; 1993.

Evans, R. C., Burlew, A. K., Oler, C. H. (1988). Children with sickle cell anaemia: parental relations, parent-child relations, and child behavior. *Social Work*, 33: 127–130.

Fowler, M. G., Whitt, J. K., Lollinger, R. R. et al. (1988). Neuropsychological and academic functioning of children with sickle cell anemia. *Journal of Developmental and Behavioral Pediatrics*, 9, 213-20.

Graham, A. V., Reed, K. G., Levit, C., Fine, M., & Medalie, J. H. (1982). Care of a troubled family and their child with sickle cell anaemia. *Journal of Family Practice*, 15: 23–32.

Hairman, L. M. F., Griffith, E. R., Hurtige, A. L., et al. (1991). Functional out comes of children with sickle cell disease affected by stroke. *Arch. Phys. Med. Rehabilitation*, 72, 498-502.

Hattie, J. A., Myers, J. E. & Sweeney, T. J. (2004). A factor structure of wellness: Theory, assessment, analysis and practice. *Journal of Counseling and Development*, 82 (3): 354–364.

Hurlock, E. B. (1972). *Child development:* New York, McGraw-Hill.

Hurtig, A. L., & White, L. S. (1986). Psychosocial adjustment in children and adolescents with sickle cell disease. *Journal of Pediatric Psychology*, 11(3), 411-427.

Jahoda, M. (1956). *Current concepts of positive mental health:* New York: Basic Books, Inc; 1956.

Knight, S., Singhal, A., Thomas, P. et al. (1995). Factors associated with lowered intelligence in homozygous sickle cell disease. *Arch. Dis. Child*, 73, 316-20.

Knight, S., Singhal, A., Thomas, P., & Serjeant, G. (1995). Factors associated with lowered intelligence in homozygous sickle cell disease. *Archives of disease in childhood*, 73(4), 316-320.

Levenson, J. L., McClish, D. K., Dahman, B. A., Bovbjerg, V. E., De A. Citero, V. & Penberthy, L. T., et al. (2008). Depression and anxiety in adults with sickle cell disease: The PiSCES project. *Psychosomatic Medicine*, 70 (2): 192-196.

Morgan, S. A. & Jackson, J. (1986). Psychological and social concomitants of sickle cell anemia in Adolescents. *Journal of Pediatric Psychology*, 11 (3): 429-440.

Noll, R. B., Vannatta, K., Koontz, K., Kalinyak, K., Bukowski, W. M., & Davies, W. (1996). Peer relationships and emotional well-being of youngsters with sickle cell disease. *Child development*, 67(2), 423-436.

Ogre, S. C., Chakravarty, M., Shrivastava, P., & Janghel, G. (2016). Relationship between somatic problems and their coping strategies among sickle cell anaemic adolescents. *Indian Journal of Health and Wellbeing*, 7(5), 510.

Platt, O. S., Brambilla, D. J., Rosse, W. F., Milner, P. F., Castro, O., Steinberg, M. H. & Klug, P. P. (1994). Mortality in sickle cell disease: Life expectancy and risk factors for early death. N. *England Journal of Medicine*, 330: 1639– 1644.

Sano, M., Haggerty, R., Kugler, S. et al. (1996). Neuropsychiatric Neuropsychology *Behavioral Neurology*, 9, 242-247.

Schatz, J. & Roberts, C. W. (2005). Short term memory in children with sickle cell disease: Executive versus modality-specific processing deficits. *Archives of Clinical Neuropsychology*, 20, 1073-1085. Doi. 10.1016/J.com.2005.06.008.

Schatz, J., Fink, R. L., Kellett, J. M. & Kramer, J. H. (2002). Cognitive functioning in children with sickle cell disease: A meta-analysis. *Journal of Pediatric Psychology*, 8, 739-748.

Seigel, W. M., Golden, N. H., Gough, J. W., Lashley, M. S. & Sacker, I. M. (1990). Depression, self-esteem, and life events in adolescents with chronic diseases. *Journal of Adolescence Health Care*, 11: 501– 504.

Singh, A. K. & Sengupta, A. (1983). *Manual for mental health battery*. Purchased by Ankur Psychological Agency Indira Nagar, Lakhnow; 1983.

Swift, A. V., Cohen, M. J., Hynd, G. W. et al. (1989). Neuropsychological impairment in children with sickle cell anemia. *Journal of Pediatrics*, 84, 1077-85.

Treiber, F. A., Mabe, P. A., & Wilson, G. (1987). Psychological adjustment of sickle cell children and their siblings. *Children's Health Care*, 16: 82–84.

Wasserman, A. L., Wiliamas, J. A., Fairclough, D. L. et al. (1991). Subtle neuropsychological deficits in children with sickle cell disease. *American Journal of Pediatrics Hematology Oncology*, 13, 14-20.

Whitten, C. F., Fischoff, J. (1974). Psychosocial effects of sickle cell disease. *Archives of Internal Medicine*, 133: 681–689.

Witmer, J. M. & Sweeny, T. J. (1992). A holistic model for wellness and prevention over the life span. *Journal of Counseling and Development*, 71 (2): 140–148.

**How to cite this article:** Ajagallay R, Janghel G, Bhagat V, Chanda V, Agrawal R, Naik N (2017), Psychological Study of the Persons Suffering From Sickle Cell Disease in Raigarh District of Chhattisgarh State, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.104/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.105/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Phenomenological Approach to Human Condition in Counselling and Psychotherapy

S.T. Janetius[1]*

**ABSTRACT**

Applying phenomenology to counselling and psychotherapy is not new in the field of psychology. It is a known fact that the Western models of identifying and classifying mental illness and behavioural problems do not fit well in the life-world of many indigenous communities around the world. The health concepts and healing practices differ obviously based on the life-world and belief systems. Even some of the classifications of psychosomatic sickness need to be reclassified as pneumasomatic as per the uniqueness of the experience and of specific communities (Janetius, 2015). There are also delusive healers in different communities who act as psychotherapists and mental health professionals in disguise, who help people in tune with their worldview and belief system (Janetius, 2013). Exploring the health concepts and healing practices and life-world of different communities and the uniqueness of their subjective experiences, culture-specific approaches are highly recommended for therapy to be meaningful. To this effect, phenomenology comes to the rescue of mental health professionals. This paper conceptualises and explains why and how the philosophical concept phenomenology is integrated into counselling and psychotherapy.

***Keywords:*** *Phenomenological Counselling, Indigenous Therapy, Culture-Specific Therapy, Philosophical Counselling*

The history of medicine started with a fusion of facts, folklore, and superstitions. Counselling and psychotherapy evolved from ministrations of priests, shamans, magicians, soothsayers and witch doctors of the ancient world. Understanding the human condition subjectively, these traditional healers attempted to determine the causes of both physical and emotional distress. Krippner (1988) identifies that behaviour therapy, hypnotherapy, psychodrama, NLP etc., are closely parallel to the traditional native healing methods. Contemporary psychotherapy that took a new shape from Sigmund Freud and his concept of religion as infantile neurosis paved the way to rule out many subjective experiences. Besides this, under the pretext of being very scientific in

[1] Professor, Department of Psychology, Jain University, Bangalore, India
*Responding Author

**Received: January 29, 2017; Revision Received: February 17, 2017; Accepted: February 24, 2017**

its approach, contemporary psychology has compartmentalised human condition and evaded subjective spiritual, religious or faith experiences that are inscribed in the minds of many people. Today psychologists have become aware of the importance of taking a client's cultural background into account when assessing the problem and determining treatment. Scholars recognise that most therapies are based on Western systems of psychology, which stress the desirability of individualism and independence. However, cultures of Asia emphasise different values, such as conformity, dependency on others, and obeying one's parents etc. Techniques that might be effective in the West or similar cultures might be inappropriate for a client from other cultural backgrounds. Therefore, there is a call among psychologists to situate subjective experiences of human beings in counselling and psychotherapy. As Frie (2003) points out, "with the advent of post-modernism, the unity of the individual mind, the notion of an objectivity, knowable world, and the view of language as the carrier of truth have all been implicitly or explicitly rejected… (In contrast) postmodernism asserts that the person, or subject, is not only shaped, but also subverted by the contexts in which it exists" (p.2). In order to understand human conditions of clients for effective therapy, therapists must be aware of their own cultural biases and adopt a phenomenological outlook.

It's difficult to differentiate counselling and psychotherapy. Counselling psychology that became popular after World War II served relatively healthy clients, related to interpersonal relationships, adjustment difficulties, life crises and stresses. On the other hand, psychotherapy dealt with severely disturbed individuals. Today this distinction between psychotherapy and counselling is quite vague and often used interchangeably. Psychotherapists and counsellors often treat the same kinds of problems with the same set of techniques. However, a slim difference that can still be made between counselling and psychotherapy would be: counselling is less intensive and more focused toward active listening, direction setting, and issues that don't require in-depth analysis whereas psychotherapy is more on dealing with emotional problems, neurosis, and more of therapy focused.

In the Indian context, many times advice and similar help offered by pastors, community leaders and social workers who have little or no training at all in specific fields of counselling or guidance or therapy often claim their informal help or advice as counselling and therapy. Counselling and Psychotherapy differ from such bare-foot or pseudo-counsellors. First and foremost, counselling or psychotherapy is not about advice giving. Secondly, they are specialised assistance by a mental health professional in which treatment methods and techniques are guided by well-developed theoretical frameworks.

***Counselling and psychotherapy***

Over the last few decades, the field of counselling and psychotherapy expanded enormously in the number of approaches, the numbers of people enter the profession and the numbers of clients opt for therapeutic assistance. Before 1950, psychoanalysis, the therapy module started by

Sigmund Freud that focused on the unconscious, early childhood experiences and the inner world of the client were virtually the only form of psychotherapy. In the later years, many theorists have developed many other psychodynamic therapies, some even significantly different from Freud's original techniques. In the 1950s and 1960s behavioural therapies that focus more on the learning, stimulus-response interactions emerged as a second force. In the latter years, humanistic-existential therapies known otherwise phenomenological therapies came as a third force in psychology. In the recent years, transpersonal approaches are becoming a strong force. As the number of approaches to therapy grew, the practice of psychotherapy and counselling spread from clinical to non-clinical settings, which was conducive to its becoming popular all over the world today. In India, although counselling has not penetrated the non-clinical settings like schools, industries and similar areas, the future is very encouraging.

Most dominant therapeutic approaches could be classified as (1) psychodynamic, (2) behavioural, (3) cognitive, (4) existential-humanistic, and (5) eclectic.

Psychodynamic approaches focus on the anxiety-provoking situations, unconscious mechanisms and early childhood experiences to identify clientele problems. Dream analysis and free association of clients' thoughts are some of the traditional techniques. As against the concept of the Freudian unconscious, behavioural approaches focus on the observable and measurable behaviours. All our behaviours are learned so we can unlearn; based on this principle, the behaviourists help individuals to replace the distressing behaviours with more appropriate ones. Cognitive approaches emphasise the beliefs and thoughts. Irrational beliefs or distorted thinking patterns can cause a variety of problems that lead to mental and behavioural problems and the therapist's direct people to think more rational constructive ways. Humanistic-existential approaches focus on the client's present life situation, aspirations and motivations in understanding, shaping and modifying behaviour. Therapists show empathy and care to facilitate clients toward personal realisations and decision-making, take responsibility for their actions, to accept themselves, and to recognise their own potential for growth and change. Eclectic therapy is an integrative approach to one or more theories and therapies put together. Today many therapists prefer this approach.

***Phenomenology***

Phenomenology is a philosophical perspective as well as an approach to qualitative research. Husserl understands phenomenology as a discipline that attempts to describe what is given to us in experience, without any obscuring preconceptions or hypothetical speculations (Husserl, 1970). Spiegelberg (1970) defines phenomenology as, "...the direct investigation and description of phenomena as consciously experienced, without theories about their causal explanation and as free as possible from unexamined preconceptions and presuppositions" (p. 810). The above two simple definitions make it clear that instead of making intellectual speculations about reality, phenomenology advocates to a pure description of 'what is'. In short, phenomenology turns

away from *a priori* assumptions and theories to describe the subjective experiences without hypothesising or imposing itself onto another person's understanding.

Phenomenology seeks to arrive at the essence of the *noema. Noema* & *Noesis* are technical terms in phenomenology used by Husserl to refer to correlated elements of the structure of any intentional act. *Noema* in particular stands for the object or content of a thought, judgment, or perception (Rassi & Shahabi, 2015). Through descriptive language, phenomenology identifies the phenomena, how the subjects perceive them in a given situation. It is a powerful tool for understanding subjective experiences, gaining insights into people's motivations and actions, and looking through culture-specific assumptions and indigenous wisdom. Free from hypotheses or preconceptions, the phenomenological research seeks essentially to describe rather than explain (Husserl, 1970). To this effect, a wide variety of methods are used in phenomenological approach that includes interviews, conversations, participant observation, action research, focus meetings and analysis of personal texts; in short, minimum structure and maximum depth without any theoretical and researcher bias (Gorden, 1969; Oakley, 1981; Plummer, 1983; Janetius, 2013; Measor, 1985).

***Need for Phenomenological Approach***

Phenomenology was relatively not known outside the philosophical settings before the advent of postmodern thinking. In the last few decades, its implications for psychology and other social sciences have been slowly realised (Kearney, 1984). The three European psychiatrists, Jaspers, Boss and Binswanger, were the first to apply the work of Husserl and Heidegger to make an existential approach to therapy and psychopathology (Mills, 1999).

Today there is a tendency among many psychologists to reduce the inter-human situation to mere scientific scores; also commit a mistake of treating a theory as a metaphysical assertion. This way of doing a wrong classification of relative or approximate knowledge as absolute knowledge prevents the possibility of getting a fresh data. The conventional psychology seeks to experimentally quantify human relations and ignores often the subjective understanding and experiencing the stimuli and responding. This distinction between objective and subjective vanishes in phenomenological questioning where the emphasis is on the subjective nature of all experiences.

The phenomenological approach is more appropriate for counselling and psychotherapy not only because phenomenology is about searching, describing human experiences as it appears but also it studies the life-world of people as it appears and as people experience. Belief-systems, that is, the belief of faith and the worldview that the patient and the community holds as the innermost cultural, spiritual, psychological resources for healing, are important factors for counselling psychotherapy process (Richards & Bergin, 1997).

The effectiveness of therapy depends on to a large extent on the quality of the relationship between the client and therapist. The better the rapport between therapist and client, better the outcome of therapy. This trust or rapport is possible only when a therapist has the openness to conceptualise clientele experiences. It is a known fact that the various schools of counselling and therapy originate from specific worldviews and theoretical frameworks. How a professional therapist classifies clients' presenting problems are found in DSM-V and such causes and cures are the creations of Western stereotypes and worldview. In contrast, native healers, shamans and other less professional therapists cling on to the belief system and life-world in the healing process, and such a practice is appealing to millions even today (Janetius, 2015).

In counselling and psychotherapy, culture is understood to pose a barrier to quality therapy (Santos, 1998). Psychologists are slowly becoming aware of the fact that people from different ethnocultural groups do indeed have unique thinking, behaviour and personality patterns, entirely different from what the generalised Euro-American psychological theories suggest (Trimble, 2008). These Western counselling and therapy modules do not fit to the need of people from another culture. Therefore, an effective therapist should work in harmony with background influences of the human condition specifically the tradition, life-world, environmental and geographic conditions of the clients. I am of the opinion that it is necessary that cross-cultural approach should be replaced by a culture-specific approach in identifying human conditions, clientele problems and therapeutic interventions. It is here that phenomenology puts its leg strong.

Cross-cultural psychology views culture simply as a site of variations for human behaviour, whereas, culture-specific psychology considers culture as the birthplace for psychological processes, an essential tool in therapy. Therefore, psychologists are becoming aware of cultural relativism and focus increasingly on cultural contextualization in understanding and answering human behaviour and mental health issues (Cole, 1996). It is true that the diagnostic manual of mental disorders (DSM-V) that is widely used as a standardised tool of classification of mental sickness encourages clinicians to be culturally sensitive in their therapeutic approaches. However, the classifications in DSM-V itself are cross-cultural. As Bruner (1990) points out, "Scientific psychology . . . will achieve a more effective stance toward the culture at large when it comes to recognize that the folk psychology of ordinary people is not just a set of self-assuaging illusions, but the culture's beliefs and working hypotheses about what makes it possible and fulfilling for people to live together. . . It is where psychology starts and wherein it is inseparable from anthropology . . ." (p. 32).

Postmodern counsellors and psychotherapists identify the deficiency in cross-cultural counselling and they stress the need to understand human phenomena in relation to specific culture rather than accepting generalised universal truths (Yeo, 2000). Therefore, to be a competent therapist one should be open to the subjective cultural concepts, ethnic identities, and

develop culture-specific approaches in order to understand the patients. This awareness and focus on culture-specific psychology makes phenomenology applicable in understanding and helping clients from a different socio-cultural background in their specific culture. In short, culture-specific psychology opens vistas for 'less pre-conceptions, less hypothesising, out of presupposition and assumptions', therefore, it is right to say, a competent culture-specific therapist should be a phenomenologist.

Postmodern thinkers identify existential situations as a factor in which our being presents itself to awareness and the human individual and surrounding environment are intertwined. Human beings can't be isolated from history, culture and language. Due to this fact, phenomenology has become a clinical method that explores the quality of lived experiences (Frie, 2003). As Heidegger (1962) points out 'to let that which shows itself be seen from itself in the very way in which it shows itself from itself' (p. 58). Due to this fact, from the traditional psychoanalysis to the present day transpersonal approach, we can see psychologists trying to apply phenomenology to both research and practice. For example, Freudian Psychoanalysis adopts a phenomenological approach to its therapy. As Merleau-Ponty (1979) points out, "It would be a mistake to imagine that even with Freud, psychoanalysis rules out the description of psychological motives, and is opposed to the phenomenological method; psychoanalysis has, on the contrary … as Freud puts it, that every human action has a meaning" (p. 158). In psychoanalysis, the therapist by way of free associations gives attention to anything that comes to awareness. Here, psychoanalysis is very similar to the phenomenological method. However, one can establish some differences in psychoanalysis and phenomenological interpretation: in psychoanalysis, all data are interpreted by its own theoretical assumptions, whereas phenomenological approach insists subjects interpreting their human condition from their own life-world.

When talking about the phenomenological approach in counselling and psychotherapy, it is important to understand two concepts from anthropology: *etic* and *emic*. A human condition could be studied from two basic viewpoints, namely *emic* and *etic*. The *emic* approach seeks to understand from the view of its adherents, while the *etic* approach does the same but by means of analytical tools and concepts drawn from outside (Pelto & Pelto, 1978). An *etic* approach understands the phenomenon cross-culturally whereas *emic* approach understands culture-specifically. Studying culture according to pre-established *etic* procedures impedes the discovery of cultural diversity, whereas *emic* analysis broadens the view (Headland, Pike & Harris, 1990). Moreover, the *emic* approach focuses on studying socio-cultural phenomena from within a specific cultural context and understanding, as the people from within that culture understand it (Gudykunst, 1997). The two specific areas where phenomenology can be applied to the human condition in counselling and psychotherapy would be research and practice.

***Research***

Many scholars have a prejudice towards qualitative or descriptive methodology. It is because as Heppner, Kivlighan, and Wampold (1992) point out, descriptive or qualitative research does not fit the *pure science myth* (p. 194) of the experimental research mongers who reduce research to quantitative numbers. However, many social scientists agree the fact that quantitative methods are not privileged over qualitative methods or experimental methods over naturalistic approaches (Braud & Anderson, 1998). Besides this, descriptive research allows researchers to understand many variables more fully and to develop more worthwhile and useful studies. Qualitative research designs, drawn from anthropological and other social science research methods, depend on the written or spoken words and/or observable behaviours as data sources (Bloland, 1992). The phenomenological approach fits well into this descriptive qualitative research because it involves observation and description of variables as they are distributed throughout a population.

Phenomenological research differs from ethnographic research. Ethnographic research involves observation and description of phenomena within a specific setting (Wiersma, 1995). The purpose of ethnographic research is to observe and document what occurs in particular setting without manipulating variables or imposing structure. Ethnographic research is not concerned with providing contextual data. Therefore the emphasis is on observation and description of what occurs without pre-conceived hypotheses. Such research may generate hypotheses throughout the data-collection process and/or focus observations around these hypotheses (Wiersma, 1995). While there is no control over extraneous variables as in analogue research, some argue that it is the 'naturalness' that enhances the validity of such research (Smith & Glass, 1987). Phenomenological research is similar to ethnographic research but goes further gaining the subjects' understandings of environments, involvements, and experiences. Thus, phenomenological researchers collect data by interviewing and asking the subjects how they experience specific phenomena. Bracketing, that is, the deferment of the researcher's personal prejudices and biases and horizontalization, that is, treating all data as if it were equally important, are the specific tools used (Heppner et al., 1992).

***Practice***

In every counselling and therapy session, when a therapist and client meet, there is a cross-cultural communication taking place; regardless of the racial educational or socio-economic similarities between the two parties (Owen, 1989). Rigid *etic* approach or perspective creates this cross-cultural communication. When the therapist allows the client to define the problem to the client's own satisfaction, cross-cultural outlook gives room for culture-specific outlook and this phenomenological outlook was brought out by Carl Rogers (Rogers 1951). In dealing with healing and therapy Castillo (1997) identifies disease-centred and client-centred approach. A disease-centred approach focuses on the symptoms observed and then makes a diagnosis. A client-centred approach (person-centred), on the other hand, focuses on the patient's worldview, how the client defines the illness and what the patient believes to be the cause of the illness. Consequently, a person-centred approach focuses on culture-sensitive assessment.

Examine this therapy situation: Mr X comes to me with two specific symptoms as presenting problems. a) His deceased father appears in dreams; b) He is not able to sleep. For a disease-centred therapist, here is a client who is not able to sleep and the therapy should be focused on helping the client to sleep well. Here, a specific subjective experience of Mr X is not considered as a unique experience rather it is considered a common symptom of sleep disorder. However, in the client-centred or phenomenological approach, it is not so. The uniqueness of seeing his deceased father need to be explored further and this subjective experience plays a vital role in therapeutic intervention. As Panos and Panos (2000) pinpoint, offering a culture-sensitive therapeutic assessment will consider: What are the dominant cultural values and belief systems of the client? How does the client describe his experience of seeing his deceased father? How does the client define the sleeping problem? What are the client's beliefs about the cause of sleeplessness? It is here, the salient feature of phenomenology is applied in counselling and psychotherapy. Although all the therapy approaches do make use of phenomenological approach in one way or another, humanistic-existential therapy and transpersonal therapies are highly popular phenomenology based therapies.

The first existential therapists were European psychiatrists trained in psychoanalysis who were dissatisfied with Freud's emphasis on biological drives and unconscious processes. Existential therapists help their clients confront and explore anxiety, loneliness, despair, fear of death, and the feeling that life is meaningless. One well-known existential therapy is logotherapy, developed by Austrian psychiatrist Viktor E. Frankl in the 1940s. Person-centred therapy, originally called client-centred therapy, is perhaps the best-known form of phenomenology-based therapy developed by Carl Rogers in the 1940s and 1950s. In this form of therapy, people are helped toward growth, maturity, and life enrichment in their own perspective rather than the clinician.

*Transpersonal Therapy:* The word transpersonal comes from two words: *trans* (beyond or through) and *persona* (mask or *façade*). At first transpersonal approach in psychology and psychotherapy became widely used to refer to any human experience related to religion, spirituality, meditation and mysticism (Daniels, 1998). However, today it covers a wider variety of subjective phenomena, not necessarily religious or spiritual. It is also a process of harmonious blending of subjective experiences in psychology, which are often neglected by traditional, conventional therapeutic approaches. Lajoie & Shapiro (1992) identify five elements as the basic characteristics of transpersonal psychology. They are: (a) an interest in states of consciousness, (b) concern with humanity's highest or ultimate potential, (c) human experience that goes beyond ego or personal self, (d) the idea of transcendence, and (e) a spiritual dimension in human life. Abraham Maslow, the architect of humanistic psychology, is considered one of the pioneers of transpersonal psychology. The great importance Maslow gave to self-actualization, peak experiences etc as the highest attainable motivations and goals of humans, place him as the great explorer of the transpersonal in human beings (Walsh & Vaughan, 1993). A transpersonal

approach sees human beings as intuitive, mystical, psychic and spiritual (Hendricks & Weinhold, 1982). Psychology considers development and the formation of a stable, integrated, and individuated ego as the goal of human development and mental health whereas transpersonal psychology exceeds such description of psychological theories and explores stages of personality development that extend beyond the individual ego into transpersonal realms (Wilber, 2000). However, it is important to distinguish bizarre phenomenon from transpersonal experience or phenomenon. Daniels (1998) argues that any event or experience or phenomenon that has a transformational meaning or an effect on a person can be considered the subject matter for transpersonal psychology. Therefore wide ranges of paranormal experiences are included in the subject matter of transpersonal psychology.

## CONCLUSION

Today there is a great awareness among psychologists and postmodern thinkers to move from cross-cultural paradigm to culture-specific approach in understanding the human condition. Phenomenology comes in as a qualitative research method as well as a therapeutic approach to facilitate clients to make sense of their life-world. Thus, with the help of *emic* understanding, grounded in phenomenological approach, a therapist-client relationship can be improved for a genuine understanding of the life-world and thus resolve wide varieties of clientele problems in counselling and psychotherapy.

***Acknowledgments***

The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Bloland, P. A. (1992). *Qualitative research in student affairs*. LA: University of California.

Braud, W. & Anderson, R. (1998). *Transpersonal research methods for the social sciences*. New Delhi: Sage Publications.

Bruner, J. ( 1990). *Acts of meaning*. Cambridge: Harvard University Press.

Castillo, R. J. (1997). Cultural assessment. "In" R. J. Castillo, *Culture and mental illness* (pp. 55-75). CA: Brooks/Cole.

Cole, M. (1996). *Cultural psychology: A once and future discipline.* Cambridge: Harvard University Press.

Daniels, M. (1998). Transpersonal psychology and the paranormal. *Transpersonal Psychology Review*, 2(3), 17-31.

Frie, R. (2003). (Ed.) *Understanding experience*. New York: Routledge.

Gorden, R. L. (1969). *Interviewing: Strategy, Techniques & Tactics*, Homewood: Dorsey.

Gudykunst, W. B. (1997). Cultural variability in communication. *Communication Research,* 24 (4): 327-348.

Headland, T. N., Pike K. L., & Harris M. (1990). (Ed.). *Emic and Etics: The insider/outsider debate*. London: Sage Publications.

Heidegger, M. (1962). *Being and time*. Oxford, Basil Blackwell.

Hendricks, G., & Weinhold, B. (1982). *Transpersonal approaches to counseling and psychotherapy.* London: Love Publishing Company.

Heppner, P. P., Kivlighan, D. M., & Wampold, B. E. (1992). *Research design in counselling*. CA: Brooks/Cole.

Husserl, E. (1970). *Logical investigations* New York, Humanities Press

Janetius, S.T. (2013). *Delusive Healers of India*, USA: Amazon CreateSpace.

Janetius, S.T. (2015). *Kabunianism and Pneumasomatic Sickness:Cordillera people in the Philippines*, USA: AmazonCS.

Kearney, R. (1984). *Dialogues with contemporary continental thinkers*. Manchester University Press.

Krippner, S. (1988). Shamans: The first healers. In G. Doore (Ed.), Shaman's path: *Healing, personal growth and empowerment* (pp. 101-114). Boston: Shambala Publications.

Lajoie, D. H., & Shapiro, S. I. (1992). Definitions of transpersonal psychology: The first twenty-three years. *Journal of Transpersonal Psychology*, 24 (1), 79-98.

Measor, L. (1985). 'Interviewing: a Strategy in Qualitative Research' in R Burgess (ed) Strategies of Educational Research*: Qualitative Methods. Lewes: Falmer Press*

Merleau-Ponty, M. (1979). Phenomenology of perception. The humanities press. N.J.

Mills, J. (1999). In search of a method: New directions in philosophical counselling. Paper presented at Canadian Society for Philosophical Practice, *Ontario Philosophical Association.*

Oakley, A. (1981) '*Interviewing women: a contradiction in terms' in H Roberts (ed) Doing Feminist Research*. London, Routledge & Kegan Paul.

Owen, R. I. (1989). *The application of some ideas from anthropology to counselling, therapy and cross-cultural counselling*. Uxbridge University Press.

Panos, P. T., & Panos, A. J. (2000). A model for a culture-sensitive assessment of patients in health care settings. *Social Work in Health Care*, 31(1), 49-62.

Pelto, P. J., & Pelto, G. H. (1978). *Units of observation: "Emic" and "Etic" approaches. In: Anthropological research: The structure of inquiry.* Cambridge University Press.

Plummer, K. (1983) *Documents of Life: an introduction to the problems and literature of a humanistic method*. London, Unwin Hyman.

Rassi, F. & Shahabi, Z. (2015). Husserl's Phenomenology and Two Terms of Noema and Noesis, *International Letters of Social and Humanistic Sciences*, Vol. 53, pp. 29-34.

Richards, P. S., & Bergin, A. E. (1997). A Spiritual strategy for counseling and psychotherapy. Washington, D.C.: *American Psychological Association.*

Rogers, C.R. (1951) *Client-centred therapy.* Boston: Houghton Mifflin.

Santos, D. (1998). *Multicultural perspective in three international schools in the Philippines. In: Bernado, (Ed.),Understanding behavior bridging cultures* (pp 159 – 166). Manila: De La Salle University Press.

Smith, M. L., & Glass, G. V. (1987). Research and evaluation in education and the social sciences. *Englewood Cliffs, NJ: Prentice-Hall.*

Spiegelberg, H. (1970) *Phenomenology, in: Encyclopedia Britannica*, vol. 17 (14th ed), pp. 810-812.

Trimble, J.E. (2008). *Cultural considerations and perspectives for providing psychological counseling for Native American Indians.* In: Pedersen PB, Draguns JG, Lonner WJ, Trimble JE, editors. Counseling Across Cultures. Los Angeles, CA: Sage.

Walsh, R., & Vaughan, F. (Eds.). (1993). Paths beyond ego: The transpersonal vision. LA: Tarcher-Putnam.

Wiersma, W. (1995*). Research methods in education* (6th ed.). Boston: Allyn and Bacon.

Wilber, K. (2000). *Sex, ecology, spirituality: The spirit of evolution*. Boston: Shambhala.

Yeo, A. (2000). Counseling *trends in postmodernist thinking in counseling*. In: Clemeña (Ed.), Counseling in Asia (pp. 6-19). Manila: De La Salle University Press.

**How to cite this article:** Janetius S (2017), Phenomenological Approach to Human Condition in Counselling and Psychotherapy, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.105/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.106/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Relationship between Insight and Spirituality in Individuals with Schizophrenia

Mr. Deepshri Phukan[1]*, Dr. Maitreyee Dutta[2]

**ABSTRACT**

The primary aim of this study was to understand the relationship among insight into illness and spirituality in patients with schizophrenia. Patients diagnosed with schizophrenia according to ICD-10 (F20-F20.9) were approached and explained about the purpose of the study. Initially patients were screened out on BPRS to rule out severe psychopathology. Only those patients who fulfilled the inclusion and exclusion criteria and provided written informed consent were recruited. Sociodemographic and clinical details were obtained from the patients, care givers and treatment records. Following this, patients were asked to complete the Birchwood's Insight Scale (BIS) and FACIT-SP-12 scale. Applied statistical methods were Descriptive statistics, Non-parametric test (Mann-Whitney U- test and Kruskal-Wallis test) and Pearson product moment correlation method. In this study significant negative correlation was found between total insight scores and "peace" domain of spirituality; on the other hand total spirituality score was significantly negatively correlated with "awareness of disease" domain of insight. The domain of "awareness of disease" also negatively correlated with "peace" domain of spirituality.

***Keywords:*** *Schizophrenia, Insight, Spirituality*

Consensus has emerged that the concept of insight is both a multidimensional and a continuous construct. Amador and David (1998) provided a multidimensional concept of insight that includes- awareness of mental illness, understanding of the social consequences of disorder, awareness of the need of the treatment, awareness of specific sign and symptoms of the disorder and attribution of the symptoms to the disorder. Earlier studies use categorical approach, dividing patients into those with and without insight and those with some or partial insight. Recent studies have involved in studying insight as a continuous process rather than the all-or-none or partial concept. Insight is assessed in graded manner and structured schedules are used to

[1] Clinical Psychologist, Dept. of Clinical Psychology, LGBRIMH, Tezpur, Assam, India
[2] Associate Professor, Dept. of Clinical Psychology, LGBRIMH, Tezpur, Assam, India
*Responding Author

**Received: January 29, 2017; Revision Received: February 17, 2017; Accepted: February 24, 2017**

capture component of insight quantitatively. Insight is regarded as a continuum of thinking and feeling, affected by numerous internal and external variables (Singh.K, Anup.P, 2008).

Insight Scale (IS), which is used in this study, devised by Birchwood et al (1994) is a self report measure to assess insight through three dimension- awareness of symptoms, awareness of disease and need for treatment.

There is many view point regarding the meaning of 'spirituality' and its relationship with religion. Spirituality refers to any experience or way of life, religious or otherwise, which can help the person to detach from the trivia, transcend and reach a calming and reassuring level of connectedness, meaning and purpose. Koenig (2009) stated that religion is conceptualized as an organized and established set of sacred beliefs, practices and rituals practiced by a group of people, where as spirituality is often interpreted as a more individual and personal structured set of beliefs. Religiosity refers to the degree of participation or adherence to the beliefs and practices of an organized religion (Mueller et al, 2001). Spiritual well-being relates to life affirming relationships, creative energy, the wholeness of an individual's spirit and unifying dimension of health, faith in a High power, enhancement of the individual's inner resources and inner strength (*Young C, Koopsen C. 2004).*

In this study, for the purpose of measurement of spirituality The Functional Assessment of Chronic Illness Therapy- Spiritual Wellbeing Scale is used which consists of subscales- faith, meaning and peace.

The relationship between insight and quality of life is paradoxical. A Karaow and FG Pajonk (2008) found contradictory result regarding the relationship between insight in to illness and quality of life in patients with schizophrenia. Previous studies found an inverse or no significant association; recent studies reported greater insight is significantly associated with an increase in depression and poor subjective quality of life. They summarized that patients with good insight might realize their restriction more clearly and the stigma of being mentally ill and the need for treatment or hospitalization are psychological strains. (*Karaw A, Pajonk FG, 2006)*. Lack of insight seems to place person at risk for rejecting helpful treatments, poor social and vocational function. On the other hand awareness of illness puts persons at risk for depression, low self-esteem and helplessness (Lysaker et al, 2009). Another one factor is stigma. Lysaker et al (2007) have suggested that internalized stigma may be the factor which mitigates the impact of whether insight can lead to improved quality of life.

Concerning this conflict between insight and quality of life, one possible explanation is the meaning that attached to schizophrenia by the patient. Insight is a personal construct that is established within a life story; in Jaspers' words, it is within the knowledge of self-existence. Patient gives meaning to any illness in the construct of meaning of life. From transcendental

point of view, there are two forms of living- one in which events follow one another without noticing them, without stopping to think over them. Another one is when life itself is perceived deep inside; through crisis human being start to know what human beings are. If a schizophrenic patient lives through a second type of living then his/her meaning attached to the illness will be different which will lead to a different quality of life than the others who lives first type of living. In terms of loss in schizophrenia, if it focuses on the remaining of the strengths of the patient rather than on the lost or what is no longer possible then the patient's quality of life will take a new form. Recovery will be a meaning making process. This meaning making process take the person as a whole person, as the quality of life of a patient evaluate the patient as a whole person. Regarding this whole perspective new formulation has emerged as 'Biopsychosociospiritual' formulation (*Josephson, A.M, Peteet, J.R 2004).* Existential themes added by spiritual approach involved hope, identity, morality, meaning and autonomy. This spiritual approach by referring the person as a whole person can give an answer to the paradox between the insight and quality of life in schizophrenic patient.

Spirituality seems to be a coping mechanism in mental illnesses. Spirituality relates to positive outcome and improves wellbeing of patients. Review of literature reveals that there is almost nonexistence of study regarding the relationship between insight and spirituality.

## METHODOLOGY

### *Need of the study*

Here, the need is to assess the relationship between these variables, because literature suggests that there is almost a non-existence of literature regarding the relationship between insight and spirituality, and the dearth of application of spiritual dimensions in clinical practice of mental health as well as in research.

### *Aims and objective*

The primary aim of this study was to understand the relationship among insight into illness and spirituality in patients with schizophrenia who were undergoing treatment as outpatients in LGBRIMH, Tezpur, Assam. *Objectives:* To examine the Socio-Demographic characteristics of the patients' and to find out the relationship between Insight and Spirituality in patients with schizophrenia.

### *Operational Definitions*

***Insight:*** Operationally insight is conceptualized as patient's awareness to the illness as well as patient's awareness about the symptoms. Insight comprises patient's awareness to treatment adherence and willingness to adhere to the treatment process. Insight is defined as consisting of three dimensions- awareness of illness, the capacity to relabel psychotic experiences as abnormal and treatment compliance.

***Spirituality:*** It is defined as personal quest for understanding awareness to ultimate questions about life, about meaning and about relationship with the sacred or transcendent which might or might not be related to religious rituals. Patient's feelings of inner peace, meaning of life and their faith on transcendent were comprised within the definition of spirituality in this study. In various literatures spirituality and religiousness were used synonymously, so in this study these two terms used as synonymously most of the time.

***Schizophrenia:*** Here schizophrenia is defined according to ICD-10 guidelines. Schizophrenic disorders are characterized in general by fundamental and characteristic distortion of thinking and perception and by inappropriate or blunted affect.

### *Research Design*

The research design employed was descriptive and cross-sectional design. *Setting:* The study was conducted at Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tezpur, Assam, Out Patient Department.

### *Sample and Sampling Method*

The population was consisting of all male and female persons between 18 to 60 years diagnosed with schizophrenia (ICD-10, DCR-10; F20-20.9). Sixty persons diagnosed with Schizophrenia (F20-20.9) according to ICD-10 (DCR-10) who's BPRS scores was found to be below 31 were taken using purposive sampling method.

### *Inclusion Criteria*

1. Diagnosed as per ICD-10(DCR-10) guidelines (F20-F20.9), (WHO,1993)
2. Those who are maintaining treatment on OPD basis at LGBRIMH.
3. Score below 31 in BPRS.
4. Between 18 to 60 years of age.
5. Patients of both sexes.
6. Patients with an education background of minimum of eighth standard.

### *Exclusion Criteria*

1. History of substance abuse.
2. Presence of organic brain disorder
3. Mental retardation.
4. Presence of psychopathology interfering in eliciting reliable information.

### *Description of Tools*

**SOCIO-DEMOGRAPHIC AND CLINICAL DATA SHEET:** It is semi structured and self prepared Performa contains information about sociodemographic variables like age, education, marital status, religion, ethnicity, community, employment status, domicile background, family

type and socioeconomic status. It also contains two clinical variables like age at onset of illness and duration of illness. *BRIEF PSYCHIATRIC RATING SCALE (BPRS):* The Brief Psychiatric Rating Scale (BPRS) Expanded version 4.0 is a 24 item rating scale constructed by Overall et.al (1962) measuring positive symptoms, general psychopathology and affective symptoms. Each item is rated on a 7 point scale (1=not present to 7=extremely severe). The reliability for the original version (Overall & Gorham, 1962), was reported to be inter-rater reliability of 0.56-0.87.

**FACIT-SP-12(Version 4) Scale (Functional Assessment of Chronic Illness Therapy-Spiritual Wellbeing):** The FACIT-SP was developed in the 1990's to address the need for a brief, broad measure of spiritual well being with content not limited to any one religious or spiritual tradition. It consists of 12 items and three sub-domains of spiritual well being, which helps facilitate an in depth exploration of the components that constitute spiritual well being (peace, meaning and faith). All of the FACIT-SP questionnaires were designed for self administration and use a 5 point Likert type scale to measure patient reported health related quality of life (0= not at all, 1= a little bit, 2=somewhat, 3= quite a bit and 4= very much). The recall period for each question is seven days. Questions were written at the fourth grade-reading level as measured by the Lexile Framwork. The scale also has the option to complete the questionnaire by interview which decreases the burden for patients whose condition or mood preclude them from completing the questionnaire on their own, although this may increase the completion time. The internal reliability of the subscales was found to be $\alpha$= 0.81-0.88 and there were moderate to strong correlation between the total FACIT-SP subscales score and the other Health Related Quality of Life Scales.

**BIRCHWOOD INSIGHT SCALE (IS):** Birchwood's Insight Scale is a self-report insight scale for psychosis. This scale consists of eight uncomplicated and direct statements that the patient rates on a 3-point scale (agree, disagree, unsure) that can be completed quickly by even seriously disturbed patient. The test items were designed to assess each of the three dimensions of insight advocated by David (1990): Awareness of Illness, Ability to relabeled Symptoms and Awareness of need for Treatment. Reliability and validity of the Birchwood's Insight Scale are found to have internal consistency ( Cronbach's alpha= .75) and test-retest reliabilities (.90) over a one week interval. The scale has adequate construct, criterion and concurrent validities and sensitivity to individual differences and changes.

***Procedure***

Patients diagnosed with schizophrenia according to ICD-10 (F20-F20.9) were approached and explained about the purpose of the study. Initially patients were screened out on BPRS to rule out severe psychopathology and recruited who scored below 31. Only those patients who fulfilled the inclusion and exclusion criteria and provided written informed consent were recruited. Sociodemographic and clinical details were obtained from the patients, care givers and

treatment records. Following this, patients were asked to complete the Birchwood's Insight Scale (BIS) and FACIT-SP-12 scale. Informed consents were obtained by assuring the confidentiality of information.

*Statistical analysis:* Statistical analyses were done using Statistical Package for Social Science (SPSS) version 20. For sociodemographic and clinical variables, frequencies and percentages were computed for discontinuous variables (e.g- gender, religion, education etc.) and means and standard deviations were computed for continuous variables (age, duration of illness, and age at onset). Descriptive analysis done and means and standard deviations were calculated for scores on BIS and FACIT-SP-12. Non-parametric tests- Kruskal Wallis test and Mann Whitney U test, were used to study differences in scores of two scales (BIS and FACIT-SP-12) with regard to Gender, Education, Marital Status, Religion, Ethnicity, Community, Employment, Domicile, Family type and Scocioeconomic Status. Pearson product moment correlation test was used to study the relationship between the scores of two scales and age, age at onset and duration of illness. Pearson's product moment correlation test was used to study the relationship among various domains of BIS and FACIT-SP-12.

## RESULTS

Applied statistical methods were Descriptive statistics, Non-parametric test (Mann-Whitney U-test and Kruskal-Wallis test) and Pearson product moment correlation method.

All the results of data interpretation were summarized in the following headings:

1. Descriptive analysis and variable association between insight and sociodemographic and clinical variables (table 1).
2. Descriptive analysis and variable association between spirituality and sociodemographic and clinical variables (table 2).
3. Relationship between Insight and Spirituality (table 3).

The mean age of the participants was 33.42 years. Most of the patients were male (81.7%), while female were 18.3%. Majority of the participants belonged to the educational level of viii-x (65%). Among all the participants 58.3% were unmarried and 30% were married participants, while 3.3% and 8.3% were separated and divorced respectively. Most of the participants belonged to the Hindu religion (81.7%) and most of them were nontribal (86.7%). Unemployed participants were more than the employed (41.7% and 10% respectively). In the category of professional/others, participants were more (48.3%) than the other categories which comprise all the participants who are living by cultivating on their own land and involving professional work. Majority were from rural background (91.7%) and from nuclear family (60%). While there were no participants from upper socioeconomic status most of them were from low middle socio-economic status (31.7%). The mean age of onset was 25.53 years and the mean total duration of illness was 7.98 years.

Statistically significant differences were found between two domicile status (urban and rural) and insight (P=.025). We observed significant negative correlation between age and spirituality (r=-.293, p=.023) (Table-2). Significant differences were found between two categories of ethnicity (tribal, nontribal) and spirituality (P=.054). Spirituality was significantly different in various levels of socioeconomic status (P=.044) (table-2).

Table 3 shows that among the three domains of Insight only Awareness of Disease had significant negative correlation with the domain of Peace of FACIT-SP-12 (r=-.485, P=.000) and total FACIT-SP-12 spirituality scores (r=-.327, P=.011). On the other way the domain of Peace had significant negative correlation with total Insight scores (r=-.377, P=.003). There was no significant correlation between total Insight scores and total FACIT-SP-12 Spirituality scores, although table shows negative correlation.

***Table 1: Descriptive analysis and variable association between insight and sociodemographic and clinical variables***

| **Variable** | **Mean** | **SD** | **P~value** |
|---|---|---|---|
| Age | 33.42 | 7.962 | r=.110 p=404 |
| Age of onset | 25.53 | 7.15 | r=.183 p=.163 |
| Total duration of illness | 7.98 | 4.96 | r=-.065 p=.624 |
| **Variable** | **n (%)** | **Insight** | **P~value** |
| Sex | | | |
| Male | 49(81.7%) | 29.80 | .540¥ |
| female | 11(18.3%) | 33.64 | |
| Education | | | |
| viii-x | 39(65%) | 30.06 | .205± |
| 10+2 | 13(21.7%) | 36.50 | |
| Graduate | 8(13.3%) | 22.88 | |
| Marital status | | | |
| Unmarried | 35(58.3%) | 26.90 | .152± |
| Married | 18(30.0%) | 38.28 | |
| Separated | 2(3.3%) | 28.00 | |
| Divorced | 5(8.3%) | 28.70 | |
| Religion | | | |
| Hindu | 49(81.7%) | 30.37 | .900¥ |
| Islam | 11(18.3%) | 31.09 | |
| Ethnicity | | | |
| Tribal | 8(13.3%) | 28.88 | .775¥ |
| Non-tribal | 52(86.7%) | 30.75 | |
| Employment | | | |
| Unemployed | 25(41.7%) | 32.70 | .640± |
| Employed | 6(10%) | 31.75 | |
| Professional/others | 29(48.3%) | 28.34 | |

| | | | |
|---|---|---|---|
| Domicile status | | | |
| Urban | 5(8.3%) | 14.10 | **.025¥** |
| Rural | 55(91.7%) | 31.99 | |
| Family structure | | | |
| Nuclear | 36(60%) | 32.11 | .375¥ |
| Joint | 24(40%) | 28.08 | |
| Socio-economic status | | | |
| Low | 17(28.3%) | 37.09 | .199± |
| Upper low | 14(23.3%) | 27.11 | |
| Low middle | 19(31.7%) | 25.79 | |
| Upper middle | 10(16.7%) | 33.00 | |

*¥ Mann-Whitney U test, ± Kruskal-Wallis test.*

***Table 2: Descriptive analysis and variable association between spirituality and sociodemographic and clinical variables***

| **Variable** | **Mean** | **SD** | **P~value** |
|---|---|---|---|
| Age | 33.42 | 7.962 | r=-.293 p=**.023** |
| Age of onset | 25.53 | 7.15 | r=-.197 p=.131 |
| Total duration of illness | 7.98 | 4.96 | r=-.202 p=.122 |
| **Variable** | **n (%)** | **Spirituality** | **P~value** |
| Sex | | | |
| Male | 49(81.7%) | 30.11 | .716¥ |
| female | 11(18.3%) | 32.23 | |
| Education | | | |
| viii-x | 39(65%) | 32.04 | .487± |
| 10+2 | 13(21.7%) | 25.38 | |
| Graduate | 8(13.3%) | 31.31 | |
| Marital status | | | |
| Unmarried | 35(58.3%) | 31.34 | .956± |
| Married | 18(30.0%) | 28.69 | |
| Separated | 2(3.3%) | 28.75 | |
| Divorced | 5(8.3%) | 31.80 | |
| Religion | | | |
| Hindu | 49(81.7%) | 31.70 | .259¥ |
| Islam | 11(18.3%) | 25.14 | |
| Ethnicity | | | |
| Tribal | 8(13.3%) | 41.56 | **.054¥** |
| Non-tribal | 52(86.7%) | 28.80 | |
| Employment | | | |
| Unemployed | 25(41.7%) | 29.40 | .898± |
| Employed | 6(10%) | 29.92 | |
| Professional/others | 29(48.3%) | 31.57 | |
| Domicile status | | | |
| Urban | 5(8.3%) | 34.80 | .565± |

| | | | |
|---|---|---|---|
| Rural | 55(91.7%) | 30.11 | |
| Family structure | | | |
| Nuclear | 36(60%) | 29.53 | .595¥ |
| Joint | 24(40%) | 31.96 | |
| Socio-economic status | | | |
| Low | 17(28.3%) | 25.62 | **.044±** |
| Upper low | 14(23.3%) | 23.04 | |
| Low middle | 19(31.7%) | 38.11 | |
| Upper middle | 10(16.7%) | 34.80 | |

*¥ Mann-Whitney U test, ± Kruskal-Wallis test.*

***Table 3: Relationship between Insight and Spirituality***

| Spirituality Insight | Meaning | Peace | Faith | Total Spirituality score |
|---|---|---|---|---|
| Symptoms | r=-.038<br>p=.774 | r=-.103<br>p=.432 | r=.163<br>p=.204 | r=.010<br>p=.940 |
| Disease | r=-.166<br>p=.205 | **r=-.485**<br>**p=.000** | r=-.083<br>p=.531 | **r=-.327**<br>**p=.011** |
| Treatment | r=060<br>p=.649 | r=-.175<br>p=.181 | r=.116<br>p=.377 | r=-.003<br>p=.983 |
| Total Insight score | r=-.087<br>p=.507 | **r=-.377**<br>**p=.003** | r=.089<br>p=.498 | r=-.170<br>p=.195 |

*Significant* $P < 0.05$

## DISCUSSION

The participants were aged between 20 to 53 years of age. Regarding the relationship between age and the two study variables results indicate that increasing age has significant negative correlation with spirituality. It suggests that younger age group has more meaning, faith and peace in life; as age increases spiritual wellbeing decreases. In a study done by Stojkovic et al (2012) found that faith was more present in respondents from the youngest age group and their condition greatly strengthened their faith or spiritual beliefs. Youngest age group had a strong attitude that everything would be fine regardless of the disease. As a person progresses through the stages of a chronic disease, his or her desire for death often elevates, and that for many people, there could be an associated decline in spiritual well-being (Jason M. Bredle et al, 2011). There was no difference between male and female in any of the two study variables. In this study significant difference was found among various socioeconomic status concerning spirituality. Income is an important parameter in socio economic status. Ruesh et al (2004) mentioned that income was markedly and negatively related to subjective quality of life. Social support explains the better subjective quality of life of severe mentally ill people. Significant difference was found among various domicile background concerning insight, as opposed to previous study, with highest mean rank to rural background. It should be interpreted cautiously as there were few patients from urban and semi urban background compared to rural background. In this study age

of onset of illness and duration of illness are selected as clinical variables but no significant relationship found with two study variables.

Regarding the relationship between insight and spirituality the literature is almost non-existent. In this study no significant correlation was found between total insight scores and total spirituality scores. But significant negative correlation was found between total insight scores and "peace" domain of spirituality; on the other hand total spirituality score was significantly negatively correlated with "awareness of disease" domain of insight. The domain of awareness of disease also negatively correlated with peace domain of spirituality. This negative relationship can be explained by associated depression and stigma in schizophrenia diagnosis. As the awareness of illness leads to depressive symptoms and stigma can make the diagnosis of schizophrenia more distressing to the patient (Ampalan, 2012) and disturbs the inner peace. Lack of insight is characteristic features of schizophrenia, but on the path of spiritual growth insight is ever present (Patil.SS, 2007)

***Limitation of the study***

As a cross sectional study and as the sample size is small the results of the study might not be applied to a large scale population. The treatment pattern of the patients is not considered so it may color the results. There was no representative from upper socioeconomic status and illiterate are not included so generalization to large scale is not suitable for this study. The samples are taken from outpatient department so the results cannot be generalized for long staying in-patients who are not functioning enough. Above all it is a co-relational study so the causal inference cannot be made between variables. Regarding clinical variables only age of onset of illness and duration of illness are considered. In some socio-demographic variables gross difference has been found between categories and applying non-parametric statistical test to those variables can limit the statistical power. The FACIT-SP-12 scale to assess spirituality is applied only in few studies concerning mental health specifically in the population of schizophrenic patient, so the comparison and substitution of results found to be difficult.

***Clinical Implication***

Results can have indirect but important implications for clinical practice. Improving quality of life is a holistic approach in treatment process of psychiatric disorders. Spirituality can help to cope with stresses in life and improve mental health. Clinicians might be helpful in understanding patient's spiritual dimensions and to incorporate in therapeutic process.

***Acknowledgments***

The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES


Amador, X. F., & Gorman, J. M. (1998). Psychopathologic domains and insight in schizophrenia. *Psychiatr Clin North Am*, 21(1), 27-42.

Ampalam, P., Deepthi, R., & Vadaparty, P. Schizophrenia - insight, depression: a correlation study. *Indian J Psychol Med*, 34(1), 44-48.

Birchwood, M., Smith, J., Drury, V., Healy, J., Macmillan, F., & Slade, M. (1994). A self-report Insight Scale for psychosis: reliability, validity and sensitivity to change. *Acta Psychiatr Scand*, 89(1), 62-67.

Jason M. Bredle., John M. Salsman., Scott Debb., Benjamin J. Arnold and David Cella (2011) "Spiritual Well-being as a Component of Health-Related Quality of Life: The functional Assessment of chronic illness Therapy- Spiritual Well-Being Scale (FACIT-Sp), *Religion*, ISSN 2077-1444, Vol. 2, 77-94.

Josephson, A. M., & Dell, M. L. (2004). Religion and sprituality. *Child Adolesc Psychiatr Clin N Am*, 13(1), xv-xvii.

Karow, A., & Pajonk, F. G. (2006). Insight and quality of life in schizophrenia: recent findings and treatment implications. *Curr Opin Psychiatry*, 19(6), 637-641.

Karow, A., Pajonk, F. G., Reimer, J., Hirdes, F., Osterwald, C., Naber, D., et al. (2008). The dilemma of insight into illness in schizophrenia: self- and expert-rated insight and quality of life. *Eur Arch Psychiatry Clin Neurosci*, 258(3), 152-159.

Koenig, H. G., & Bonelli, R. M. Mental disorders, religion and spirituality 1990 to 2010: a systematic evidence-based review. J Relig Health, 52(2), 657-673.

Lysaker, P. H., Davis, L. W., Warman, D. M., Strasburger, A., & Beattie, N. (2007). Stigma, social function and symptoms in schizophrenia and schizoaffective disorder: associations across 6 months. *Psychiatry Res*, 149(1-3), 89-95.

Lysaker, P. H., Vohs, J. L., & Tsai, J. (2009). Negative symptoms and concordant impairments in attention in schizophrenia: associations with social functioning, hope, self-esteem and internalized stigma. *Schizophr Res*, 110(1-3), 165-172.

Mueller, P. S., Plevak, D. J., & Rummans, T. A. (2001). Religious involvement, spirituality, and medicine: implications for clinical practice. *Mayo Clin Proc*, 76(12), 1225-1235.

Ruesch, P., Graf, J., Meyer, P. C., Rossler, W., & Hell, D. (2004). Occupation, social support and quality of life in persons with schizophrenic or affective disorders. *Soc Psychiatry Psychiatr Epidemiol*, 39(9), 686-694.

Singh, S. K., Fischer, U., Singh, M., Grebe, M., & Marchant, A. (2008). Insight into the early steps of root hair formation revealed by the procuste1 cellulose synthase mutant of Arabidopsis thaliana. *BMC Plant Biol*, 8, 57.

Stojkovic et al. Faith and adjustment to chronic diseases. *SEEHSJ* 2012; 2(1):52-61.

Young, R. & Rohrer, J. E. (2004). Self-esteem, stress and self-rated health in family planning clinic patients. *BMC Fam Pract*, 5, 11.


**How to cite this article:** Phukan D, Dutta M (2017), Relationship between Insight and Spirituality in Individuals with Schizophrenia, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.106/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.107/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Exploring Depression and Coping Strategies among the Widowed and Divorced Working Women

Dr. Meera Manjul[1]*, Rajender K. Premi[2]

**ABSTRACT**

The present investigation was designed to explore the prevalence of depression among single married working women (widow and divorced) to see the relationship between tribal and non-tribal with special focus on their coping strategies. The data was collected from 100 widowed and divorced women (50=divorced; 50=widows). In both the groups of women, 25 were tribal and non-tribal women in each group. The correlational analysis was done to find out the relationship of depression, and coping strategies between the above mentioned groups. The results also indicate that depression is significantly higher among widow than the divorced participants both in case of tribal and non-tribal than the divorce tribal and non-tribal and as well the coping style is significantly better and effective in case of divorced tribal and non-tribal than the widow tribal and non-tribal. Therefore, the results indicate that better the coping style lower the depression.

***Keywords:*** *Depression, Coping Style, Widow, Divorced Women*

World Health Organization has ranked depression as leading cause of morbidity in developing nations like India. The dreary aspect of depression is that is itself being an illness breeds many other sorts of health hazards. Generally, it refers to a set of conditions, which lead to the deterioration of both physical and psychological functioning and is referred to as common cold of psychopathology at once familiar and mysterious. Feldman (1990) on the basis of review of empirical evidences suggested that women are prone to the spells of depression, ranging from mild through moderate to major depressive disorders.

The women in general and widows and divorced in particular confront depression directly in three visible areas, family, working place, and society that affects their physical and psychological health. Singh (2000) has concluded that in India, frequency of mental illness is

[1] Faculty Member, Life Long Learning Department, HP University, Shimla, Himachal Pradesh, India
[2] Research Scholar, Department of Sociology, HP University, Shimla, Himachal Pradesh, India
*Responding Author

**Received: January 27, 2017; Revision Received: February 17, 2017; Accepted: February 24, 2017**

higher in females than males and the genesis of mental illness is more social psychological than biological. Jaco (1980) has found that manic-depressive disorders were significantly higher among divorced than among the married and 66.9% of Khorana's (1989) sample were widows who have developed heart disease. The women-without-men are more or less prone to depression which is a form of mental illness that remains almost invisible due to lack of knowledge of its symptoms on the part of the individual and specifically, the tendency of scarifying their health among women for their family members. Many other times, its symptoms are overlooked and taken for granted as normal occurrence (Broota and Kumari, 1998).

In the patriarchal system of India society widowhood and divorce hood are depression generating events in life. These events still encompasses social restrictions, curtailed social participation, feeling of insecurity and many other socio-economic and health problems including depression, anxiety, tension (Hussain and Sharma, 1994; Khan and Khan,1994; Singh and Misra,1987; Khorana,1989; Srivastava and Sinha,1989). A part of their problems are due to their being women living under stressful conditions. Besides, Premi (2004) has argued that much of their problems arise out of their status of being a 'women-without-men'. The significance attached to the word without-men is that these women due to loss of their husbands play certain roles and do certain works which otherwise would have been done by their husbands.

Widowed and divorced/separated women constitute significant proportion of the nation's population. As per Census of India 2011, widowed/divorced/separated (W/D/S) females constitute 8.2 percent of the total population. They are unevenly distributed in all parts/States of India ranging from 4.7 percent lowest to 12.4 highest in Bihar and Kerala respectively. Percentage distribution of population by marital status and sex is given in table 1.1.

***Table 1.1Percentage distribution of population of India by marital status and sex***

| **Sex** | **Marital Status** | | |
|---|---|---|---|
| | **Never married** | **Married** | **W/D/S** |
| Male | 52.5 | 45.2 | 2.3 |
| Female | 42.9 | 48.9 | 8.2 |
| Total | 47.8 | 47.0 | 5.2 |

*Source: Census of India, 2011 (Total may not add to 100 percent due to rounding)*

The data in table 1.1 reflects that the proportion of women-without-men is higher than 'men-without-women' at national level by 5.9 percent. These signify that women tend to remain widowed or divorced for longer time than their marital partners. The State of Himachal Pradesh has also considerable population of such females. Data for the State of Himachal Pradesh is tabulated in table 1.2.

*Table 1.2 Percentage distribution of population of Himachal Pradesh by marital status and sex*

| Sex | Marital Status | | |
|---|---|---|---|
| | Never married | Married | W/D/S |
| Male | 51.1 | 46.4 | 2.5 |
| Female | 40.0 | 50.9 | 9.2 |
| Total | 45.4 | 48.7 | 5.9 |

*Source: Census of India, 2011 (Total may not add to 100 percent due to rounding)*

In respect of widowed/divorced/separated population, it can be seen that average W/D/S population is 5.9 percent in HP which is higher than the national average of 5.2 percent. In case of females i.e. women-without-men, the average is 9.2 percent which is also more than the national average of 8.2 percent by 1 percent in Himachal Pradesh.

It is argued that in the traditional societies where men tend to earn for family and women work inside home, widowhood and divorce hood put a pressure on such women for making living of their family by working outside home. While working outside home, for survival, is a compulsion for them their stressful life events tend to increase and the working conditions for widowed and divorced women have never been conducive for their physical and psychological health (Pandey and Srivastava, 2000). Thus, it may be said that they constituted signification proportion of the population and their health concerns deserves to be given serious attention.

***Concept of Depression and Coping***

Depression is understood as a form of mood disorder. The mood associated with normal depression vary in length, sleep difficulties, eating problems and thoughts of despair and at the end of disorder spectrum is psychotic depression, in which a person lose contact with reality, and may develop delusion and retardation. Though it is difficult to ascribe universally accepted symptoms of depression, the following symptoms have been found to have been existing in the person living with depression:-

1. ***Mood*****:** It is estimated that more than 90% of depressed people experience prolonged moods of sadness and crying occurs not only in response to specified experiences, but also because of miner frustration and sometime even for no apparent reason.
2. ***Thought*****:** Depressed persons tend to manifest loss of interest, decrease in energy, inability to accomplish tasks difficulty in concentration, and the erosion of motivation and ambition all combine to impair efficient functioning.
3. ***Behaviour and Appearance*****:** The persons under depression reflect dejected face and attitude. While this may be interrupted by an occasional smile, particularly if he/she thinks that it is expected of him, the smile is usually frozen and superficial that has earned the name mirthless.
4. ***Cleanliness*****:** Their clothes may be sloppy and even dirty. Personal hygiene may be neglected. Women are, normally, found to be unconscious of their hair.

5. ***Speech*:** It has been noticed that depressed person's spontaneous speech is reduced and they attempt little to initiate conversation. In very severe cases, retardation becomes so marked that the patient becomes mute and almost stupor.
6. ***Loss of appetite and weight*:** The person under depression may show a marked loss of appetite and weight loss particularly as the illness progresses.
7. ***Constipation*:** It is assessed that when the depression may become quite severe and the patient may have ten days or more without a bowel movement.
8. ***Sleep disturbance*:** It is found that the person under depression complain of difficulty in falling asleep, restlessness, awaking during the night and inability to return to sleep but quite contrarily some people sleep excessively when depressed.
9. ***Aches and pains*:** It is ascertained that the patients complain of dry mouth, aches and pains, headaches, neuralgia, tight feelings in the chest, and difficulty in swallowing.
10. ***Menstrual Changes*:** It is found that depressed women frequently report changes in their menstrual cycle and mostly a lengthening of the usual.

Having the above mentioned symptoms, the person in the state of depression invariably show self-negation and in extreme spell of depression, he may attempt or commit suicide. Further, it is also found that there is variation in characteristics of depression across life span. Bogadia et al (1974) have observed that the cases of depression showed higher incidences during monsoon period. Based on depression variations, depression has been classified into two categories-Manic Depressive Type and Depressive Type (Carson and Butcher,1992). While manic depressive type includes, hypomania, acute mania, hyper-mania, depressive type is a state of emotion marked by sadness, feeling of loss of interest in life activities The DSM-IV attempts to differentiate depression from normal sadness along the history and is manifested in seasonal affective disorder, dysthymia, mild depressive, moderate depression, major depression, and depressive stupor. The other kind of classification of depression involves simple depression, acute depression, hyper acute depression and agitated depression.

Depression has been found to been influenced by biological and psychological factors (Money and Ehrhardt, 1972; Wig et al, 1969; Sethi and Gupta, 1970) like heredity, age, gender, family genetics, hormonal imbalance, and medical conditions. In case of women it is estimated that women are two to three times more likely than men to suffer from depression. Many empirical evidences have supported this view that women are more prone to depression due to gender and social position and the various life events. However, the human beings have tendency to manage their balance by way of coping strategies.

Coping, in general, is defined as effort, both action-oriented and intrapsychic, to manage i.e. master, tolerate, reduce minimize environmental and internal demands with a motive to reduce conflicts. Empirical evidences have shown than depressed people cope with stressful events (Haghighatgou, 1995). Dise-Lewis (1988) has found that life stress was significantly correlated

with measures of anxiety, psychosomatic symptoms and depression. In the same line, Kolence et al (1990) studied the relationship of mild depression to stress and coping and administered the Beck Depression inventory. Their result suggested that depressed subjects were engaged in less problem focused coping than non-depressed subjects. Desenova et al (1994) in their study of depression and copying style revealed a significant main effect for emotion focused coping on depression. Subjects who used more emotion-focused coping also experienced more depression. No interaction effects or main effects for problem-focused coping were found.

***Objective and Hypothesis***

Having the foregoing background and a brief review of literature, it has been presumed that that depression would be negatively correlated with coping strategies and low coping strategies leads to high depression.

For testing this hypothesis, and given to widowed and divorced women's high probability for undergoing depression on account various socio-economic, biological and psychological factors, it has been decided to assess the depression and copying strategies of widowed and divorced working women. Further, in the study are also lived tribal women, therefore, it was also endevoured to seek assessment of depression among widowed and divorced women separately for tribal and non-tribal women.

## MATERIAL AND METHODOLOGY

This study has been carried out in the Shimla city of Himachal Pradesh. This city is the capital of the State and comprises of the population from different part of the State. Besides, this city being main hub for employment in governmental and non-government sector as most of the State offices, Universities and other educational institutions are situated in and around this city.

Correlational design was used to study the relationship between depression, and coping style among the sample of the study on these variables. The sample is of 100 working women (50 widowed+50divorced). In the each ground of widowed and divorced women, 25 were of tribal origin and 25 were non-tribal.

The sample was given Multidimensional Coping Inventory Scale (Charles et al, 1989). Five scales of multidimensional coping inventory (four items each) measure conceptually distinct aspects of problem focused coping (active coping, planning, suppression of competing activities, restraint coping, seeking of instrumental and social support), five scales measures aspects of what might be viewed as emotion focused coping (seeking of emotional social support, positive reinterpretation, acceptance, turning to religion and denial) have been used. Further, for scoring, responses choice of each question was given the weight age from 1 to 4. Each response choice that the subject responds as right was summarized up for active coping, planning, and suppression of competing activities and so on for the ten sub-scales. The sample was also

administered Hindi Version of Beck's Depression Inventory (1961). The scale is used for measuring attitudes and symptoms associated with depression. It is a 21-items scale with the total score ranging from 0 to 63. Although, these have been some controversy concerning the use of the BDI Beck, Steer and Garbin (1998) has reviewed a large number of studies that demonstrates the reliability and validity of the measure. In this, score of twenty-one questions will be added and the total score will be obtained. The highest score or each of the twenty-one questions is three; the highest possible total for the whole-test is sixty-three. The lowest possible score for the whole test is zero.

The participants of the study were contacted through resource women, who were requested to arrange interaction session with tribal and non-tribal widow and divorced employed women respectively. In this session the participants were given a brief overview of the concepts of depression, and coping style. After that they were contacted individually by the investigator and were assured that the information given by them would be kept confidential. After establishing a good rapport with the subjects, they were asked to respond any one alternative of each item by marking a tick. They were again assured that the data so collected should only be used for academic purpose. After collecting all the questionnaires, scoring was done as per the instruction given in the scoring manuals of each variable of depression and coping style.

## RESULTS AND DISCUSSION

The present investigation was designed to explore the prevalence of depression among single married working women (widow and divorced) to see the relationship between tribal and non-tribal with special focus on their coping strategies. The data was collected from 100 widowed and divorced women (50=divorced; 50=widows). In both the groups of women, 25 were tribal and non-tribal women in each group. The correlational analysis was done to find out the relationship of tribal, non-tribal widow and divorced women with depression, and coping strategies on these variables between the above mentioned groups.

First of all, inter-correlations among coping style and depression were computed. The results indicated that depression is significantly and negatively correlated with copying style ($r=-.302^{**}$, $P<0.01$) in whole group ($N= 100$) of tribal and non-tribal, widow and divorced employed women. To be specific, in case of tribal women ($N=50$), depression is significantly and negatively correlated with copying style ($r=-.232^{*}$, $p<.05$) and that the depression is correlated negatively and significantly with copying style ($r=.-299^{*}$, $p<.05$) in case of non-tribal participants ($N=50$). The depression score for tribal widows is significant ($r=-.588^{**}$, $p<0.01$) and negatively correlated with copying style. In case of non-tribal widows, depression is significantly and negatively correlated with copying style ($r=-.312^{*}$, $p<.05$).

In case of tribal divorced women, depression is significantly and negatively correlated with copying style ($r=-.241^{*}$,$p<.05$) and that the depression is negatively and significantly correlated

with coping style among non-tribal divorced (r=-.490*,p<.05). In nutshell, the results indicate that depression is significantly and negatively correlated with copying strategy among tribal widows, tribal divorced and tribal in whole; non-tribal widows, non-tribal divorced and non-tribal in whole and tribal and non-tribal in whole employed women participants.

It can be summarized that depression is negatively and significantly correlated with coping styles in all the participant groups which state that higher the level of depression lower the use of effective coping styles. And Further, the results also indicate that depression is significantly higher among widow than the divorced participants both in case of tribal and non-tribal than the divorce tribal and non-tribal and as well the coping style is significantly better and effective in case of divorced tribal and non-tribal than the widow tribal and non-tribal. Therefore, the results indicate that better the coping style lower the depression. These findings do find support through some others direct and indirect studies who have reported that problem-solving and affective regulation styles of coping were correlated negatively with depressive symptoms and that emotional discharge and avoidance styles of coping were correlated positively (Coyne et al, 1981). Thus on the basis of discussion it can be safely inferred that depression is negatively related with coping style and the hypothesis that there is significant difference on depression among tribal and non-tribal widows and divorces women.

***Acknowledgments***
The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Beck., A. T., Ward, C. H., Mendleson, M., Mock, J. &Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 4, 561-71.

Bogadia, V. N., P. V. Pradhan, I. P. Shah (1974), "Ecology and Psychiatry in Bombay." *International Journal of Social Psychiatry*, 40-302.

Carson, R. C.; James N. Butcher (1992) *Abnormal psychology and Modern Life* (9th edition). New York: Harper Collins.

Census of India (2011). www.Census2011.co.in./census /city/4-shimla.html.

Coyne, J. C; Cotlib, I. H. (1983), "The role of cognition in depression: A Critical appraisal". *Psychological Bulletin*, 4, 472-503.

Dise-lewis, Jeane D. (1988), "The Life Events and coping inventory: An assessment of stress in children". *Psychosomatic Medicine*, 50(5), 484-99.

Feldman, S. Shilley; Fisher, Lawrence; Ransom, Donald C; and Dimiceli; Sue. (1995) "Sex differences in relations between adolescent coping and adult adaptation." *Journal of Research on Adolescence*, 5(3), 333-59.

Haghighatgou, Hedien; &Plterson, Christopher, (1995), "Coping and depressive symptoms among Iranian students."*Journal of Social Psychology*, 135(2), 175-80.

Jaco, A. G. (1960), *The Social Epidemiology of mental Disorders.* New York: Sage Foundation.

Khorana, Suman A. (1989), "Psychological Risk Factors in Ischemic Heart Disease." *Indian Journal of Clinical Psychology*, 16, 13-17.

Kolence, Koleen M; Hartley, Duane & Murdock, Nancy L. (1990), "The relationship of mild depression to stress and coping." *Journal of Mental Health Counseling*, 12(1), 76-92.

Levitt, E. E. &Lubin, B. (1975), *Depression*. New York: Springer Publishing.

Pandey, Shushma, Srivastaya, Shipra (2000), "Coping with work Stress: The role of Job Category, Family Type and Job Tenure" *Journal of Research And Applications in Clinical Psychology*, 3, 18-21.

Premi, Rajender K. (2004), *Working Women, Living without Men: A Sociological Study*. An Unpublished M. Phil Dissertation , HP University, Shimla.

Sethi, B. B. & Gupta, s. C. (1970), "An epidemiological and cultural study of Depression" *Indian Journal of Psychiatry*, 12, 13-22.

Singh, Jitendrakumar (2000), "Psychological intervention for Facilitating mental health in village: An Experimental report."*Journal of Research and Application in Clinical Psychology*, 3, 28-32.

Srivastava, G. P., Sinha, S. P. (1989), "Stressful Life Events and Health' *Indian journal of Clinical Psychology*, 16, 26-28.

Wig N. N. H. C. Verma, D. K. Shah(1969), "Parental depression and Mental Illness". *Indian Journal of Psychiatry*, 11, 1-6.

**How to cite this article:** Majul M, Premi R (2017), Exploring Depression and Coping Strategies among the Widowed and Divorced Working Women, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.107/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.108/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# ICT Tools Usage among Faculty of Education in Teaching Learning Processes

Dr. M. Jagadesh[1]*

**ABSTRACT**

Information and communication technologies (ICT) is defined, as a "diverse set of technological tools and resources used to communicate, and to create, disseminate, store, and manage information". The present study aims to study the usage of different ICT tools used by the faculty of Education in effective curriculum transaction. A rank analysis is done based on their responses to a data sheet. The emphasis of orientation and awareness programs for the faculty is signified in the study. To reach the goal of preparing teachers for effective technology use, a well-designed professional development program is essential. ICT can not only improve learning; but can also break down teacher and student stereotypes and boost self-esteem and would revolutionize the higher education system.

***Keywords:*** *ICT, Curriculum Transaction, Professional Development Program*

Since the 1980s, the integration of computer technologies in education has been a challenge for many educational systems throughout the world. In educational reforms the teacher is the last but most crucial chain in the process of educational change. ICT stands for information and communication technologies and is defined, as a "diverse set of technological tools and resources used to communicate, and to create, disseminate, store, and manage information."

To reach the goal of preparing teachers for effective technology use, a well-designed professional development program is essential. Professional development in a technological age requires new definitions and new resources. It cannot take the traditional forms of individual workshops or one-time training sessions. Instead, it must be viewed as an ongoing and integral part of teachers' professional lives.

As a result, the use of technology enables teachers to implement new teaching techniques, to help students work collaboratively and develop higher-order thinking skills, to encourage

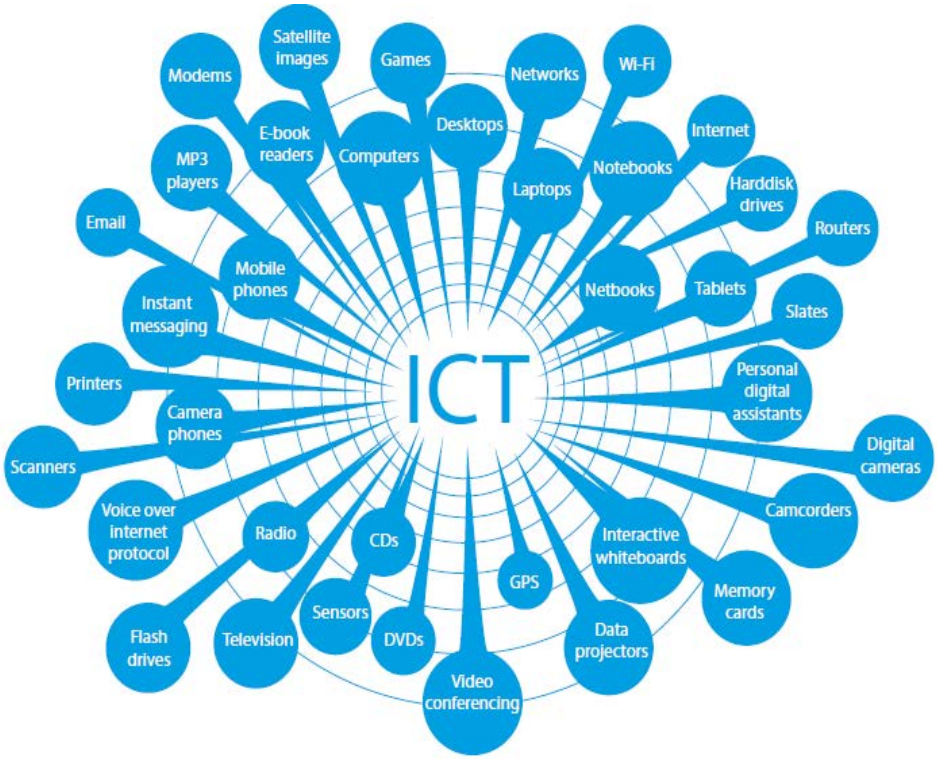
[1] Assistant Professor, Dr. NGP College of Education, Coimbatore, Tamil Nadu, India
*Responding Author

**Received: January 31, 2017; Revision Received: February 18, 2017; Accepted: February 24, 2017**

students to be engaged in the learning process, to assist students who have various learning styles and special needs, and to expose students to a broad range of information and experts.

***Background of the study***

Globally, there is a lack of research addressing the adoption of ICT in higher education and the effective use of hardware components of ICT used in teaching learning processes. In this study, the focus is on what is termed hardware – the components of ICT like the computer itself, storage media, and input and output devices. A teacher should have the pre-requisite competencies in handling these tools to quench the thirst of students with varied discipline and abilities. ICT is making it increasingly easy for teachers and students to have access to a broader range of materials than they can use in the classroom.




***Objectives of the present study***

1. To study the usage of ICT tools among faculty of Education in teaching learning process.
2. To rank the most used ICT tools by the faculty in effective curriculum transaction.

## METHODOLOGY

Descriptive method is used in the present study. Eighty faculties from 22 colleges of Education were selected in random for the study.

***Tools used***

The tool is used to collect the personal information about the teachers. Here the information regarding the Age, Gender, Educational Qualification, Designation, and Teaching Experience, Administrative Duties held in institutions and Internet Access at home are collected. In addition, a tool containing different ICT tools is given. Teachers respond to it based on their experience and know-how of the ICT tools. After obtaining the responses, the usage of ICT tools were scored as "High", "Medium" and "Low".

***Table 1: Frequency and Percentage on Personal Variables***

| Sl.No | Variables | | Frequency | Percentage |
|---|---|---|---|---|
| 1 | Gender | Male | 37 | 46.25 |
| | | Female | 43 | 53.75 |
| 2 | Educational Qualification | MEd | 49 | 61.25 |
| | | MPhil/PhD | 31 | 38.75 |
| 3 | Internet Access at home | No | 21 | 26.25 |
| | | Yes | 59 | 73.75 |
| 4 | Age | Upto 30 Years | 22 | 27.50 |
| | | 31-39 Years | 34 | 42.50 |
| | | 40 Years & Above | 24 | 30 |
| 5 | Designation | Lecturer | 71 | 88.75 |
| | | Assistant Professor | 2 | 2.50 |
| | | Associate & Professor | 7 | 8.75 |
| 6 | Teaching Experience | Upto 5 Years | 42 | 52.50 |
| | | 6 to 10 Years | 26 | 32.5 |
| | | Above 10 Years | 12 | 15 |

***Table 2: Rank Analysis on ICT tools usage***

| Usage of ICT | Sum | Mean | Std. Deviation | Rank |
|---|---|---|---|---|
| Computer and Mobile Apps | 183 | 2.288 | 0.660 | 6 |
| Email distribution list | 181 | 2.263 | 0.590 | 7 |
| Web portals | 171 | 2.138 | 0.707 | 11 |
| Windows Office (Word, Excel, Power point, Outlook) | 201 | 2.513 | 0.636 | 1 |
| Podcast | 152 | 1.900 | 0.739 | 16 |
| Blogs | 149 | 1.863 | 0.725 | 17 |
| Video-streaming | 160 | 2.000 | 0.636 | 14 |
| Local Area Network | 191 | 2.388 | 0.606 | 3 |
| LCD | 199 | 2.488 | 0.574 | 2 |
| Smart classrooms | 186 | 2.325 | 0.652 | 5 |
| Interactive boards | 180 | 2.250 | 0.720 | 8 |
| Network drives/ Cloud Computing | 159 | 1.988 | 0.755 | 15 |
| Personal Digital Assistants | 161 | 2.013 | 0.755 | 13 |
| GPS and GIS in Classrooms | 159 | 1.988 | 0.771 | 15 |
| Portable Electronic Keyboards | 174 | 2.175 | 0.725 | 10 |

| Usage of ICT | Sum | Mean | Std. Deviation | Rank |
|---|---|---|---|---|
| Digital Cameras/ Scanners/ Printers | 190 | 2.375 | 0.663 | 4 |
| Online Courses/ Tutorials | 165 | 2.063 | 0.663 | 12 |
| Virtual labs | 165 | 2.063 | 0.735 | 12 |
| E Books and Digital repositories | 179 | 2.238 | 0.680 | 9 |
| Social Networks | 174 | 2.175 | 0.671 | 10 |

## RESULTS AND DISCUSSION

Based on the results of different ICT tools used by teachers, a rank analysis is made. Among the 20 ICT tools used by the faculty of Education, the usage of Windows office ranked the highest as it is found to be used commonly for curriculum transaction, presentations, e-assignments etc., it is followed by computers, mobile apps and digital scanners/printers. The least used ICT tools among the faculty are podcast, blogs and GPS/GIS technologies in classrooms. This reason could be the lack of awareness on these tools which has resulted in less penetration in usage. Proper training and orientation can make the usage of tools to the maximum.

## CONCLUSION

ICT will be a key factor in future positive change – provided they are in the possession of people who use them creatively and for the common good. In the new Millennium, nations are judged by the well being of their citizens; level of education is one of the major determinants. Computer literacy of a nation in future will be a yardstick to measure the level of education.

***Acknowledgments***

The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Altun, S.A. & Kalayc, E. et al., (2011). Integrating ICT at the faculty level: A case study. *The Turkish Online Journal of Educational Technology, 10(4), 230-240.*

Angad, G.R. (2014). Teachers' attitude towards information and communication technology (ICT). *International Journal of Education and Psychological Research (IJEPR), 3(1), 21-23.*

Askar, P. (2006). Logistic Regression Modeling for Predicting Task-Related ICT Use in Teaching. *Educational Technology & Society*, v9 n2, 141-151.

Berge, Z. L. (1998). Barriers to online teaching in post-secondary institutions. *Online Journal of Distance education Administration. 1(2). Summer.*

Condie, R. (2013). Blending Online Learning with Traditional Approaches: Changing Practices. *British Journal of Educational Technology*, v38 n2, 337-348.

Hisham Barakat Hussein, (2011). Attitudes of Saudi universities faculty members towards using learning management system (JUSUR). *The Turkish Online Journal of Educational Technology, 10(2), 43-53.*

Jonassen, D. H., & Reeves, T. C. (1996). Learning with technology: Using computers as cognitive tools. *Handbook of research for educational communications and technology, 693-719. New York: Macmillan.*

Keengwe, J. (2006). Faculty integration of computer technology into instruction and students' perceptions of computer use to improve their learning. *Journal of Information Technology Education, 6, 169-180.*

Schibeci, R. (2014). Teachers' Journeys towards Critical Use of ICT . *Learning, Media and Technology*, v33 n4, 313-327.

Selwood, I. (2005). Teacher Workload: Using ICT to Release Time to Teach. *Educational Review*, v57 n2, 163-174.

UNESCO. 2002a. *Information and Communication Technologies in Teacher Education: A Planning Guide* (Ed. P. Resta). UNESCO, Paris.
[Online]. Available:http://unesdoc.unesco.org/images/0012/001295/129533e.pdf

Wishart, J. (2012). PDAs and Handhelds: ICT at Your Side and Not in Your Face Technology. *Pedagogy and Education*, v16 n1, 95-110.

**How to cite this article:** Jagadesh M (2017), ICT Tools Usage among Faculty of Education in Teaching Learning Processes, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.108/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.109/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Parental Bonding and Psychological Well-Being among Young Adults

J Indumathy[1]*, K Ashwini[2]

**ABSTRACT**

The study on Parental Bonding and Psychological Well-being was conducted in Sriperumbudur among 60 young adults. The tools used were Parental Bonding Instrument and Psychological General Well – being Index. The bonding or attachment that a child has with parents have a great impact on their personality traits and well - being. Children who have a secure attachment with their parents tend to be less at the risk of any mental disorders. Parents these days are both employed and the children are left with the servant maids or at crèches, wherein they lose the bonding that has to be received from their parents. In some cases the parents are over protective to the children and restrict them in almost every single thing. This lack of parental bonding or over protectiveness may affect the well – being of the child in the later years. The present study is to know the bonding style of parents with their children and the effect of it on the psychological well-being of the individual. The results indicated that there is a significant correlation between parental care, control and psychological well – being.

***Keywords:*** *Parental Bonding, Psychological Well – Being, Young Adults*

***"It is not managing a child but raising a human being"***

**P**arents tend to have a crucial role in the lives of their children namely, teacher, playmate, caregiver and disciplinarian. The bonding or attachment that a child has with parents have a great impact on their personality and well - being. Children who have a secure attachment with their parents tend to be less at the risk of any mental disorders. Parents these days are both employed and the children are left with the servant maids or at crèches, wherein they lose the bonding that has to be received from their parents. The parent – child attachment is an excellent predictor of a child's later social and emotional development. In some cases the parents are over protective to the children and restrict them in almost every single thing. This lack of parental bonding or over protectiveness may affect the well – being and social competency of the child in the later years.

[1] M.Sc. Counselling Psychology, Rajiv Gandhi National Institute of Youth Development, Sriperambudur, India
[2] M.Sc. Counselling Psychology, Rajiv Gandhi National Institute of Youth Development, Sriperambudur, India
*Responding Author

**Received: January 31, 2017; Revision Received: February 18, 2017; Accepted: February 24, 2017**

***Parental Bonding***

Parental Bonding is an important indicator that gives a huge insight into a parent – child relationship. It can be said as an attachment between the child and the parent. The attachment theory is based on the idea that there are individual differences in terms of how infants get emotionally bonded to their caregivers and how these first attachment experiences influence the future developments of infants in social, cognitive and emotional aspects (Bowlby, 1969; 1977). Through bonding the child learns about themselves and the world around them.

***Importance of Parental Bonding***

Parental bonding is very important for the normal development of an individual. The parent – child relationship has a great influence on an individual's development than any other relationship. It tends to be the foundation for all other relationships that an individual forms in life. The bond is the source of love, trust, intimacy and security. This relationship would nourish well – being or may cause a scar in life.

Researchers claim that children who have a strong bond with parents are likely to develop a positive, responsive companion or intimacy, and would be better at adapting to difficult peers by asserting their needs. Children with a secure and caring bond with parents tend to come to a new peer relationship with positive beliefs and expectations. The child's first relationship with primary caregivers helps in learning what can and cannot be expected out of others.

The importance of bonding with the primary caregiver cannot be overestimated. Failure or lack of bonding may profoundly affect the future development and the ability to form healthy relationships as an adult. Fortunately, human beings are not completely dependent on the early moments. They have many opportunities to bond appropriately throughout the first year of life. There are also instances where mothers who adopt babies and even older children are able to form intimate attachment relationships.

It is not only the primary caregiver, but also the father and siblings bonding which has an influence on the emotional and social development of an individual. When a child is consistently responded for its need, it tends to form a trusting and lifelong relationship.

Many research studies depicts a significant relationship between the parental attachment and later psychological, social development. Securely attached children become more self – reliant and have a better sense of self – esteem. The cognitive – emotional aspect of parental bonding will exert its influence on the adolescence emotional and mental compatibility.

Researchers state that insecure bonding may lead to misinterpretation of failures as an intrinsic fault of themselves. It is also found that isolation during adolescence is the repelling effect of

early childhood experiences of insecurity or control. Low care and increased control also increases the risk of depression and lowers the self – esteem of individuals.

***Psychological Well – Being***

Psychological well – being is said to be the fundamental of mental health. According to the World Health Organization 2011, mental health is defined as "a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community". Traditionally it is said to be the absence of distressful symptoms and includes more positive qualities.

***Psychological Well – Being and Parental Bonding***

Research studies show that parental low care and non – engagement or control are associated with lower levels of psychological well – being. They are also prone so neurotic conditions like anxiety, dependency and apprehension. Parents, family and peers have an important role in influencing the psychological well – being of an individual. Parental affection, emotional warmth and empathy serve as determinants of higher well – being and mental health.

Children, adolescents and adults who have a secure attachment with their parents tend to be less prone to psychological strain and distress. It also showed a decreased likelihood or reporting suicidal ideations and attempts. Studies also showed that lack of parental care especially from the mother was reported by almost all the individuals experiencing depression, anxiety disorders and hypochondriasis.

Bowlby (1977) postulated that it is the prime responsibility of parents to provide their children a secure and affectionate base and motivate them in their later years of life to explore ahead. Parental over protection and inadequate control in childhood would result in psychological vulnerability in adult life whereas emotional warmth and high care contributes in lesser strain and higher self-esteem. Hence, all styles have positive or negative consequences, if provided in balance can contribute in the development of a healthy individual.

Parental care or control had an impact on the self – esteem and emotional intelligence of individuals. These factors are those which contribute for better psychological well – being. It is very important for the person who plays the caregiver to be very sensitive and empathetic to the child and develop a warm bonding which would give a sense of security to the child.

Several research studies also states that the early bonding formed by the caregiver and the child, i.e. first 4 – 5 years of birth is very important for every individual. Certain parenting patterns are factors influencing the emergence of mental health problems in later stages, which would have an impact on the psychological well – being of the child. Studies show that parenting patterns

play a crucial role in the social competence, academic performance and psychosocial development.

Thus it is very important for parents or care givers to have an empathetic and warm bond with their children. There must be a constant level of control and care, which would help the child to have a better psychological well – being.

## REVIEW OF LITERATURE

The study on "Parental practices predict psychological well-being in midlife: life-course associations among women in the 1946 British birth cohort" was to examine the association between well-being in midlife and parental behaviour during childhood and adolescence, and the role of personality as a possible mediator of this relationship. Data from 984 women in the 1946 British birth cohort study were analysed using structural equation modelling. Psychological well-being was assessed at age 52 years using Ryff's scales of psychological well-being. Parenting practices were recollected at age 43 years using the Parental Bonding Instrument. Extraversion and neuroticism were assessed at age 26 years using the Maudsley Personality Inventory. In this sample, three parenting style factors were identified: care; non-engagement; control. Higher levels of parental care were associated with higher psychological well-being, while higher parental non-engagement or controls were associated with lower levels of psychological well-being. The effects of care and non-engagement were largely mediated by the offspring's personality, whereas control had direct effects on psychological well-being **(Huppert, et al 2010).**

The study "Self-esteem and life satisfaction as mediators between parental bonding and psychological well-being in Japanese young adults" explored the mediating roles of self-esteem and life satisfaction in the relationship between parental bonding and general mental health among Japanese young adults. Six-hundred-eighty-two undergraduates (358 women and 324 men) completed four measures: Parental Bonding Instrument, Rosenberg's Self-esteem Scale, Satisfaction with Life Scale, and the General Health Questionnaire. A structural equation modelling procedure was used to examine the model of best fit for parental bonding (care and over-protection), life satisfaction, self-esteem, and psychological well-being. Results showed that self-esteem fully mediated the relationship between parental bonding (parental care and parental over-protection) and general mental health. This study demonstrated the mechanism through which perceived parenting style influences Japanese young adults' psychological well-being (**Yamawaki, et al 2010**).

The current study "Attachment and psychological well-being among adolescents with and without disabilities in Kenya: The mediating role of identity formation" is aimed at evaluating the relationship between attachment and identity development, and their influence on psychological well-being in adolescents with and without disabilities in Kenya. The sample was

composed of 296 adolescents (151 with disabilities and 145 without any disability). The mean age in our sample was 16.84 years (SD = 1.75). Adolescents with disabilities had significantly lower scores in identity formation, paternal attachment, and life satisfaction. A path model indicated that identity formation partially mediated the relationship between secure attachment and psychological well-being. Our findings indicate that both parent and peer attachment play an important role in the identity formation and psychological well-being of adolescents in Kenya, irrespective of a disabling condition. **(Abubakar 2013).**

The study "Parent-child relationships and offspring's positive mental wellbeing from adolescence to early older age" examined parent-child relationship quality and positive mental well-being using Medical Research Council National Survey of Health and Development data. Well-being was measured using Teacher-rated happiness, Life Satisfaction, Satisfaction with home and family life and Diener Satisfaction with Life scale and Warwick Edinburgh Mental Well-being scale. The Parental Bonding Instrument captured perceived care and control from the father and mother to age 16, recalled by study members at age 43. Greater well-being was seen for offspring with higher combined parental care and lower combined parental psychological control at all ages. Controlling for maternal care and paternal, maternal behavioural and psychological control, childhood social class, parental separation, mother's neuroticism and study member's personality, higher well-being was consistently related to paternal care. This suggests that both mother-child and father-child relationships may have short and long-term consequences for positive mental well-being. **(Stafford 2016)**

## METHODOLOGY

***Objectives***

1. To assess the style of parental bonding of the sample.
2. To assess the psychological well – being of the sample.
3. To find the relationship between parental care and psychological well – being of the sample.
4. To find the relationship between the parental control and birth order of the sample.

***Hypotheses***

The hypotheses are stated as alternate hypotheses, so that they can be either accepted or rejected based on the results.

1. There will be a significant relationship between parental care and psychological well – being.
2. There will be a significant relationship between the parental control and birth order of the sample.

***Sample***

60 college students were selected for the study from Sriperumbudur. Simple Random Sampling technique was used for data collection.

***Tools***

To collect information from the respondents, the methods of Interview, Case Study Schedule and Psychological Inventories were used. The tools used were as follows:

1. **Parental Bonding Instrument -** Gordon Parker, Hilary Tupling and L.B. Brown, 1979
   **Description -** The Parental Bonding Instrument (PBI) asks respondents to recall how their parents acted towards them during the first 16 years of their life. The questionnaire consists of 25 items with each item being rated on a 4-point Likert scale from 'very like' to 'very unlike.' Participants are asked to rate their mothers' and fathers' attitudes separately. Parker and associates 1979 reported test–retest reliability scores of .76 for the Care scale and .63 for Overprotection scale, interrater reliabilities of .85 on the care dimension and .69 on the overprotection dimension, and concurrent validity scores of .77 and .78 for the care dimension and .48 and .50 for the overprotection dimension. More recent test–retest reliabilities with a nonclinical U.S. population ranged from .79 to .81, and long-term stability scores ranged between .65 and .77 (Wilhelm and Parker 1990). Reliability analysis of participants' scores on the PBI resulted in participant alpha scores estimating internal consistency of .84 for the Care scale and .84 for the Overprotection scale.
2. **Psychological Well – being Index -** Olivier Chassany MD. PhD, Elof Dimenäs PhD; Dominique Dubois MD, FFPM and Albert W. Wu MD PhD MPH, 1970
   **Description** – The PGWBI targets peoples' self-representations of an aspect of their general well- being. It does not include an evaluation of physical health. The 22 item instrument includes six dimensions: Anxiety, Depressed Mood, Positive Well-being, Self-Control, General Health and Vitality. The 22 items are frequently used to generate an overall Index or total score for general well-being. The questionnaire takes 10 minutes or less to administer and is generally well-accepted. Internal consistency reliability levels of the PGWB and PGWB-R were comparable, with Cronbach's alpha coefficients between 0.93-0.96 for the total scale across method of administration. Intraclass correlations between the two methods were high (0.66-0.84). The PGWBI scale has satisfactory internal construct validity when tested with modern psychometric techniques.

***Analysis of the Data***

The data was analyzed statistically using SPSS package 22.0v.

1. One way ANOVA
2. Pearson Product Moment Correlation

## RESULTS AND DISCUSSION

***TABLE–I Mean and Standard Deviation of Parental Care, Parental Control and Psychological Well-being***

| Variable | Mean | Standard Deviation | t Value | Significance |
|---|---|---|---|---|
| Parental Care | 21.86 | 5.48 | 35.433 | <0.01** |
| Parental Control | 18.56 | 9.01 | 20.215 | <0.01** |
| Well-being | 59.27 | 8.45 | 32.107 | <0.01** |

***Significant at 0.01 level*

The table indicates that the variables of the study namely Parental Care, Parental Bonding and Psychological Well – Being differ across the sample. Thus the scores are normally distributed across the samples. The scores of all the variables are significant at 0.01 levels.

***TABLE – II Differences on Parental care and Parental Control based on Psychological Well-being***

| Variable | F Value | Significance |
|---|---|---|
| Parental Care | 5.570 | <0.01** |
| Parental Control | 10.501 | <0.01** |

***Significant at 0.01 level*

The above table exhibits the differences on parental care and control based on Psychological Well – being. It indicates that the sub - variables of parental bonding namely Care and Control are significant at 0.01level on psychological well – being. Thus the results support the attachment theory of Bowlby, which postulates that the attachment of a child with caregivers have an influence on the development of the child in all multidimensionality.

***TABLE - III Correlation between Parental Care, Parental Control and Psychological Well-being***

| | Parental Care | Parental Control | Psychological Well-being |
|---|---|---|---|
| **Parental Care** | 1 | | -0.594** |
| **Parental Control** | | 1 | -0.548** |

***Significant at 0.01 level*

In the above table Pearson Product Moment Correlation was used to calculate the relationship between Parental Care, Control and Psychological Well – being. There exists a negative correlation between parental care and psychological well – being. Thus when care increases, psychological well – being decreases and vice versa. There also negative correlation between parental control and psychological well – being. Thus when control increases, psychological well – being decreases and vice versa. Hence the sub – variables of parental bonding have a significant relationship on psychological well – being.

## SUMMARY AND CONCLUSION

The scores of the variables are found to be normally distributed. They are significant at 0.01 levels. Based on Psychological Well – Being, the sub – variables of Parental Bonding such as Care and Control tend to be significant at 0.01 levels.

There exists a significant negative correlation between parental care and psychological well – being. There also exists a significant negative correlation between parental care and psychological well – being.

***Acknowledgments***

The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Amichai-Hamburger, Yair (2009), *Technology and Psychological Well-being*. Cambridge University

Amina Abubakar (2013). Attachment and psychological well-being among adolescents with and without disabilities in Kenya: The mediating role of identity formation, *Journal of Adolescence* 36(5):849-57. Retrieved from https://www.researchgate.net/publication/256467108_Attachment_and_psychological_well-being_among_adolescents_with_and_without_disabilities_in_Kenya_The_mediating_role_of_identity_formation

Holden, G.W. (2010). *Parenting,* Sage publications

Huppert FA1, Abbott RA, Ploubidis GB, Richards M, Kuh D (2010), Parental practices predict psychological well-being in midlife: life-course associations among women in the 1946 *British birth cohort.* Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/19995477

Huppert, Felicia A. (2011), *Happiness and Well-being*. Vol 4, Routledge Press

Hurlock, E.B. (1988). *Developmental psychology*. Tata Mc Graw- Hill, Publications.

Niwako Yamawaki, Julie Ann Peterson Nelson and Mika Omori (2011), *Self-esteem and life satisfaction as mediators between parental bonding and psychological well-being in Japanese young adults,* Article Number - A42596514325, Retrieved from http://www.academicjournals.org/journal/IJPC/article-abstract/A42596514325

*Social Determinants of Health and Well- being Among Young People* (2012), World Health Organization

Stafford M, Kuh DL, Gale CR, Mishra G, Richards M (2016). *Parent-child relationships and offspring's positive mental wellbeing from adolescence to early older age.* Volume 11, - Issue3, Retrieved from http://www.tandfonline.com/doi/full/10.1080/17439760.2015.1081971.

V.Brett, Brown (2008), *Key Indicators of Child and Youth Well-Being*. Psychology Press

**How to cite this article:** Indumathy J, Ashwini K (2017), Parental Bonding and Psychological Well-Being among Young Adults, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.109/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.110/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Impact of Maternal Employment on Adolescents Study Habits

Dr. Smritikana Mitra Ghosh[1]*

## ABSTRACT

The purpose of the present study was to find out whether the study habits of school students of working differ significantly from those of non-working mothers. The sample of the study consisted of 200 school students (100 school students of working mothers &100 school students of non- working mothers) studying in class Xth of Ranchi town. Study Habit Inventory constructed by Hassan (2003) of P.G. Department of Psychology, Ranchi University, Ranchi was administered to the selected sample to assess their study habits. The data so collected was analyzed statistically by employing mean, SD and t-test. The study revealed there were significant differences between the adolescent students of working and non- working mothers. Adolescents of working mothers had significantly better study habits than adolescents of non-working mothers. Further the study revealed that female students had significantly better study than male.

***Keywords:*** *Study Habits, Adolescents, Working Mothers and Non-Working Mothers*

The first name which comes from baby's mouth is 'ma'. Mother is the first teacher of a child. Mother is the person who takes care of child's nutrition, hygiene, education than anyone else in the family. Working mother in the present study shall refer to educated women with educational qualification as graduation and above and is engaged in any government, semi-government or private salaried job. Non-working mother in the present study shall refer to educated women with educational qualification as graduation and above but not engaged in any government, semi-government or private job. With the emergence of a new economic pattern, increasing opportunities for education, rising standard of living and increased modernization, women from the middle and upper class families have also started coming out of their traditional role of a home maker to join the work force. The number of working women has been increasing year by year. The education of women is not imperative for the benefit for the women only but uplift of the society also. Today women from all corners started working in government, semi government or private salaried jobs. The entry of women in the workforce brings changes in the structure and function of family. Every member of the family occupies a vital position in the

[1] Ph.D, Dept. of Psychology, Ranchi University, Jharknand, India
*Responding Author

**Received: February 4, 2017; Revision Received: February 18, 2017; Accepted: February 24, 2017**

interaction map of the child but among them the role of mother is important and varied. Mother plays important role in the personality development of the children by shaping their intellectual and social behavour. The children of working and non working women differ in several areas.

***Concept of Study Habits***

Study habits are usually defined as student's ability to manage time and other resources to complete an academic task successfully. 'Study habit' is the amount and kind of studying routines which the student is used during a regular period of study occurred in a conducive environment. Study habits are the ways that we study, the habits that we have formed during our school years. Study habits can be good ones, or bad ones. Good study habits include being organized, keeping good notes, reading our textbook, listening in class, and working every day. Bad study habits include skipping class, not doing our work, watching TV or playing video games instead of studying, and losing our work. The definition of study habits are the behaviors used when preparing for tests or learning academic material. A person who waits until the very last night before an exam and then stays up all night trying to cram the information into his head is an example of someone with bad study habits. A habit is something that is done on a scheduled, regular and planned basis that is not relegated to a second place or optional place in one's life. It is simply done no reservations, no excuses, no exceptions. Crede and Kuneel (2008) defines study habit as study routines, including, but not restricted to, frequency of studying sessions, review of material, self testing, rehearsal of learned material and studying in a conducive environment. Study habits are commonly referred to as regular patterns in approaching study tasks. Study habits typically denotes degree to which students engages in regular acts of studying that are characterized by appropriate studying retains (review or material) occurring in an environment that is conducive to studying.

Study habits refer to the activities carried out by learners during the learning process of improving learning. Study habits are intended to elicit and guide one's cognitive processes during learning. Study habits are learning tendencies that enable students work privately. Study habits vary from student to student. Some habits are considered to be more desirable than others from the point of view of academic achievement. A good number of studies have been made in order to investigate the relationship between study habits and scholastic performance. Azikiwe (1998) describes study habits as "the adopted way and manner a student plans his private reading, after classroom learning so as to attain mastery of the subject". According to her, "good study habits are good asset to learners because habits helps students to attain mastery in areas of specialization and ensuing excellent performance, while the opposite becomes constraint to learning & achievement leading to failure". In recent years study skills and study habits or behaviors has been distinctly differentiated. Study habits of the children play very important role in reflecting the standards of education. Those Students who have good study habits are able to make effective study decisions, have the ability to differentiate the level of difficulty to learn the items, have high achievement motivation, socialized personality traits and problem solving

appraisal. Without good study habits, a student cannot succeed. To succeed, students must be able to appropriately assimilate course content, digest it, reflect on it, and be able to articulate that information in written and/or oral form. Key is the ability to acquire effective study skills .Study skills: study skills are usually steps or procedures such as highlighting, outlining, note-taking, summarizing etc. that may be taught through explicit instruction (Gettinger & Seibert, 2002). Study skills are the specific techniques that make up the study plan.

## REVIEW OF THE LITERATURE

The research on the effects of maternal employment on the child indicates mixed results. In a review of research on maternal employment and children's achievement for the National Academy of Sciences, Heyns (1982) concluded that "the children of working mothers differ very little from the children of non-working mothers. Another review published 2 years before found that there were measurable differences in academic performance and other measures of children's well-being depending on maternal employment status (Hoffman, 1980). Scarr (1984) noticed that school achievement of children of employed mothers was good compared to children of non-employed mothers but Gottfried and Bathurst (1988) in contrast, found that the number of hours the mothers work was negatively correlated with school achievement. Muni (1995) observed that adolescents of employed mothers had a positive physical, intellectual and educational self-concept and were better adjusted than the children of housewives.

Blau (1999) determined that income was not as important a variable with respect to cognitive development in children as other familial aspects are. It was found that permanent income, that is income from a permanent career oriented position, is slightly significant. However, changing the families' income level has no significant effect. Children in different economic classes do seem to be on different cognitive levels. Maternal employment was found to be beneficial to children in low-income families. Perhaps these children receive more stimulation or education in their day care system than they would if they were at home. It can also be inferred that mothers of low-income families are also less educated, thus having poorer parenting skills. The children of low-income families with employed mothers scored higher on the cognitive tests and had less behavioural problems than children of low-income families where the mother was not employed.

Maternal employment may have more negative effects on child outcomes for children of two-parent families, high income or highly educated families (Gregg et al., 2005; Ruhm, 2004; & Leigh & Yamauchi, 2009). Research on maternal employment measured at the same time as the child outcome was reviewed recently in a meta-analysis by Goldberg et.al, (2008). They concluded from their analysis of 68 studies that the overall association between maternal employment and children's achievement, which was the sole child outcome in their analysis, was non significant. Children of non-working parent get higher grades in high schools, but at the same time feel less pressure about doing so (Essortment, 2002). Children of working mothers do not suffer any differently from anxiety, antisocial behavior or stress related problems than those

of non-working mothers, had fever stereotyped gender-role attitudes and felt their mothers are more competent. Children of working mothers were also found to have a feeling of that they had control over their environment (Gershaw, 1988). Study conducted by Hoffman (1961) found that children of working mothers had lower intellectual performance than a matched group of children whose mother does not work. Some studies revealed that while the lack of mothers presence can impact a child negatively this impact is not as serve as what occurs if the mother does not work. Such factors include poverty, parental education and quality childcare (Booth, 2000). Abid (2006) revealed that guidance services have significant effect on the student's study attitudes, study habits and academic achievement. Significant differences were obtained in the academic achievement of students due to low and high level of goal orientation, study skills, scholarly study skills and over all study efficiency (Gakhar, 2005). Raiz et al. (2002) revealed that there existed a significant and positive relationship between achievement of the students and the said factors like schedule of study, habit of note taking and writing book. Franklin (2006) conducted a study to describe the study habits of undergraduate students who were enrolled in the initial phase of a teacher education programme at a large urban university.

The findings of the study indicate that a significant number of students study at home, cram the night before an examination, depends on other classmates to answer their questions, and feel that they spend an adequate amount of time preparing for academic classes. Lakshminarayanan et al. (2006) have made an attempt to compare achievers and non-achievers in study skills. Result in general indicates that achievers use higher level of study skills than non-achievers. Stella and Purushothaman (1993) examined the study habits of underachievers. The mean value showed that urban students had better study habits than rural students. Sud and Sujata (2006) who reported that girls have better study habits than boys. Suneetha and Mayuri (2001) also reported that boys and girls differ significantly in study habits. Harwod and Feruson (2000) and Akhani et al (1999) who reported that some areas of study habits are effected by maternal employment and some areas are not.

***Motivation of the research***

Researchers got interested in the field of education of children of working and non-working mothers, to find out the problems and benefits. Therefore, the importance of maternal employment inspired the researcher to conduct a study on study habits and maternal employment.

***Hypotheses***

1. There is no significant difference in study habits between adolescent students of working and non-working mothers.
2. There is no significant difference in study habits between male and female students.

***Sample***

Sample of the present study consisted of male and female respondents of working and nonworking mothers, studying in class X of high schools of Ranchi city. The sample split of 100 students from adolescents of working mothers and (50 male and 50 female) and 100 students from adolescents of non-working mothers (50 male and 50 female).

***Research Variables***

1. ***Independent Variable*** *-Maternal Employment*
2. ***Dependent Variable*** *- Study Habits*
3. ***Intervening Variable*** *- Male and Female Adolescents*

***Tools used for Research***

***Study Habit Test (SHT)*****:** Study habit test has been developed by Hassan (2003) of P. G. Department of Psychology, Ranchi University, Ranchi. The test covers 6 themes namely, revision, seriousness, systematic study habits, regularity, concentration and other than books. It is a four-point Likert type scale consisting of 24 items. Each item had four response alternatives: always, maximum times, sometimes and never. The responses alternatives to positive item are scored from 4 to 1 and to negative item are 1 to 4. Thus, the total range of the score is from 24 to 96, the high scores indicating better study habits.

***Procedure***

The study habits test was administered to both groups with instructions to complete all questions honestly and not to discuss the questions with fellow students. Scoring was done according to the respective scoring keys. In order to fulfill the hypotheses of the study the score obtained were analysized with mean, SD's and t value.

***Analysis of Data***

Data is by analyzed using statistical techniques like mean, SD and t-ratio. Bar diagrams graphs were drawn to make the results transparent.

## RESULT AND DISCUSSION

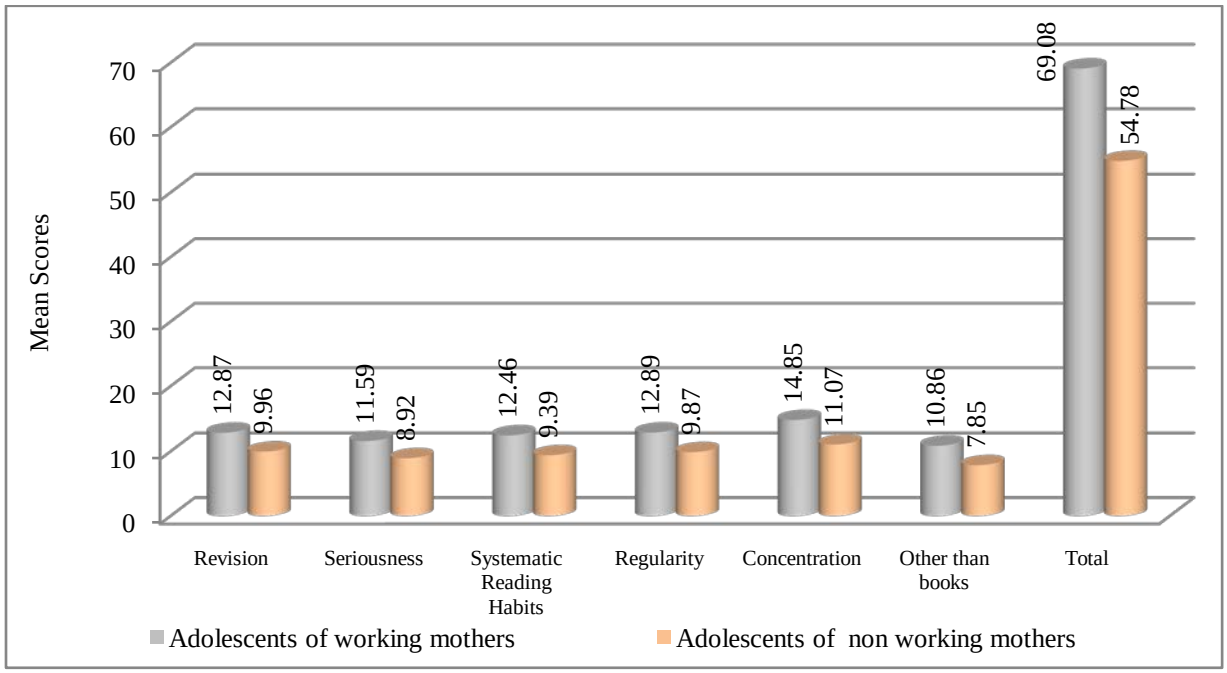
***Table –1: Means, SDs and t-ratios of adolescent students of working and non-working mothers on study habits***

| Study Habit dimensions | Groups | N | Mean | SD | t |
|---|---|---|---|---|---|
| Revision | Adolescents of working mothers | 100 | 12.87 | 3.06 | 7.86** |
| | Adolescents of non working mothers | 100 | 9.96 | 2.08 | |
| Seriousness | Adolescents of working mothers | 100 | 11.59 | 3.44 | 6.88** |
| | Adolescents of non working mothers | 100 | 8.92 | 1.79 | |
| Systematic | Adolescents of working mothers | 100 | 12.46 | 2.71 | 9.34** |

| Study Habit dimensions | Groups | N | Mean | SD | t |
|---|---|---|---|---|---|
| Reading Habits | Adolescents of non working mothers | 100 | 9.39 | 1.86 | |
| Regularity | Adolescents of working mothers | 100 | 12.89 | 3.19 | 7.82** |
| | Adolescents of non working mothers | 100 | 9.87 | 2.17 | |
| Concentration | Adolescents of working mothers | 100 | 14.85 | 2.59 | 11.18** |
| | Adolescents of non working mothers | 100 | 11.07 | 2.17 | |
| Other than Books | Adolescents of working mothers | 100 | 10.86 | 2.22 | 11.21** |
| | Adolescents of non working mothers | 100 | 7.85 | 1.51 | |
| Total | Adolescents of working mothers | 100 | 69.08 | 8.91 | 13.11** |
| | Adolescents of non working mothers | 100 | 54.78 | 6.29 | |

*** Significant at 0.01 level*

***Figure -1: Showing mean scores of adolescent students of working and non-working mothers on study habits***




The above table-1 depicts the mean scores of the student's adolescents of working mothers and non-working mothers on their study habits. The mean scores of working mothers group for revision, seriousness, systematic study habits, regularity, concentration, other than books and total study habits score is found to be 12.87, 11.59, 12.46, 12.89, 14.85, 11.07,10.86 and 69.08 and of non-working mothers group is found to be 9.96,8.92,9.39,9.87,11.07,7.85 and 54.78 respectively. All the t-values are statistically significant at 0.01 level of significance. It means adolescents of working mothers are better study habits than adolescents of non- working mothers.

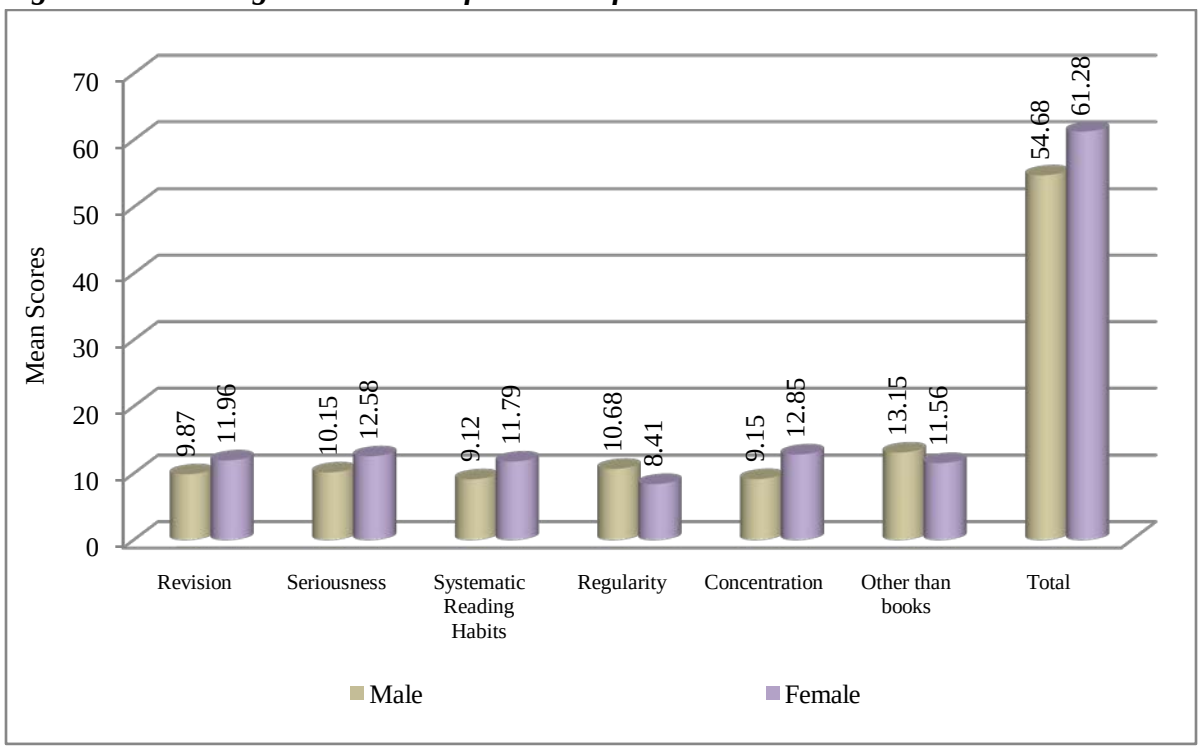
Hence the hypothesis there is no significant difference in study habits between adolescent students of working and non-working mothers is rejected. The findings of the present study have support from the observation made by Harwod and Feruson (2000).

***Table- 2 Means, SDs and t-ratios of male and female adolescents***

| Study Habit dimensions | Groups | N | Mean | SD | t |
|---|---|---|---|---|---|
| Revision | Male | 100 | 9.87 | 2.51 | 5.30** |
| | Female | 100 | 11.96 | 3.04 | |
| Seriousness | Male | 100 | 10.15 | 2.09 | 6.69** |
| | Female | 100 | 12.58 | 2.97 | |
| Systematic Reading Habits | Male | 100 | 9.12 | 2.42 | 5.78** |
| | Female | 100 | 11.79 | 3.93 | |
| Regularity | Male | 100 | 10.68 | 2.59 | 7.11** |
| | Female | 100 | 8.41 | 1.86 | |
| Concentration | Male | 100 | 9.15 | 2.68 | 9.51** |
| | Female | 100 | 12.85 | 2.82 | |
| Other than Books | Male | 100 | 13.15 | 2.47 | 4.99** |
| | Female | 100 | 11.56 | 2.01 | |
| Total | Male | 100 | 54.68 | 7.42 | 5.59** |
| | Female | 100 | 61.28 | 9.18 | |

*** Significant at 0.01 level*

***Figure -2: Showing mean scores of male and female adolescents***



A glance of the table-2 depicts that there is a statistically significant difference found between male and female groups. It was seen that compared to the male group female group are having better studying skills. In all these comparisons between male and female adolescents, females have obtained significantly higher mean scores as compared to male adolescents. All the't' ratios are significant at 0.01 level.

Hence the hypothesis "there is no significant difference in study habits between male and female students" is rejected. The findings about gender differences are in line with those of the studies by Suneetha and Mayuri (2001) and Sud and Sujata (2006).

### *Findings of the study*

1. Adolescents of working mothers are better study habits than adolescents of non- working mothers.
2. Female adolescents are better study habits than male students.

### *Limitations of the study*

1. The sample size for the present study was limited.
2. The present study included subjects from the urban localities of Ranchi only.
3. Variables like religion, area, age, types of family and socio-economic status etc. were not included in the study.

### *Acknowledgments*

The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Akhani, P., Rathi, N., & Jasore, M. (1999). Academic Achievement, Study Habits and Loneliness of Children of Employed and Unemployed Mothers. *Journal of Psychometry and Education*. 30(1), 65-57. Cited in Indian Educational Abstracts, 1(1), Jan. 2001, NCERT, New Delhi.

Blau, D. (1999). The Effect of Income on Child Development. Rev. *Econ. Stat*., 81: 261-277.

Ch. Abid, H. (2006). Effect of Guidance Services on Study Attitudes, Study Habits and Academic Achievement of Secondary School Students. *Bulletin of Education & Research,* 28(1), 35-45.

Deka, N., & Kakkar, A. (1998). The impact of maternal employment on perceived behavior and self-concept of Indian adolescents. *Journal of Indian Academy of Applied Psychology*, 24, 93-98.

Essortment. (2002). Children of Working Mothers. *Essortment*

Franklin, F.A. (2006). *Study habits of Undergraduate Education Students*. (Master's thesis). Retrieved from ProQuest Dissertations and Thesis. (UMI 1439951)

Gakhar, M. (2005). A Study of Academic Achievement of Bachelor of Psychotherapy Students Due to Different Study skills. *Journal of Education & psychology*, 63(4), 31-37.

Goldberg, W. A., Prause, J. A., Lucas-Thompson, R., & Himsel, A. (2008). Maternal employment and children's achievement in context: A Meta analysis of four decades of research. *Psychological Bulletin, 134*, 77–108. doi:10.1037/0033-2909.134.1.77.

Gregg, P., E. Washbrook, C. Propper & S. Burges (2005), "The Effects of a Mother's Return to Work Decision on Child Development in the United Kingdom", *The Economic Journal*, Vol. 115, pp. F48–F80.

Harwod, J.L. & Ferguson, D.M. (2000). A longitudinal study of maternal labour force participation and child academic achievement. Retrieved from *psychological Abstract*, 2000, 84.

Heyns, B. (1982). *The influence of parents' work on children's school achievement*. In S. B. Kamerman & C. D. Hayes (Eds.), Families that work: Children in a changing world (pp. 229-267). Washington, DC: National Academy Press.

Hoffman, L. W. (1980). The effects of maternal employment on the academic attitudes and performance of school-age children. *School Psychology Review*, 9, 319- 336.

Lakshminarayanan, T.R., Suresh, A., & Kumari, K.A. (2006). Achievers and Non-Achievers Compared in Study Skills. *Journal of Community Guidance & Research*, 23(3), 292-295.

Leigh, A. and C. Yamauchi (2009), "*Which Children Benefit From Non-Parental Care*?" (http://people.anu.edu.au/andrew.leigh/research.htm)

Mittal, S. (1997). Self-concept and scholastic achievement of children of working mothers and non-working mothers. *Journal of Community Guidance and Research*, 14, 47-52.

Muni, A.K. (1995). Effect of maternal employment on adolescents' self-concept and adjustment .*International Journal of Behavioural Sciences*, 13

Raiz, A., Kiran, A., & Malik, N.H. (2002). Relationship of Study Habits with Educational Achievements. *International Journal of Agriculture & Biology*. 4(3), 370-37.

Ruhm, C. (2004), "Parental employment and child cognitive development", *Journal of Human Resources*, Vol. 39, No.1, pp. 155–92.

Scarr. (1984).*Mother care-other care*. New York: Basic Books.

Stella & Purushothaman, S. (1993). Study habits of underachievers. *Journal of Educational Research and Extension*, 29(4), 206-214.

Sud, A., & Sujata. (2006). Academic performance in relation to self-handicapping, test anxiety and study habits of high school children. *Psychological Studies- University of Calicut*, 51(4), 304-309.

Suneetha, B., & Mayuri, K. (2001). A study on age and gender difference on the factors affecting high academic achievement. *Journal of Community Guidence and Research*, 18(2), 197-208.

**How to cite this article:** Ghosh S (2017), Impact of Maternal Employment on Adolescents Study Habits, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.110/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.111/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Role of Physical Activity in Mental Well-Being

Ravi Kumar[1]*

**ABSTRACT**

Regular physical activity plays a vital role in both psychological and physiological well-being of people of all ages. Mental well-being, a psychological wellbeing, which is mostly influenced by physical activity. The purpose of the present study is to conceptually investigate the role of physical activity in mental well-being. This paper has focused on exploring physical activity and mental well-being on the basis of Review of Literature, which helped in developing the theoretical framework. The finding of this paper is that the physical activity helps to improve mental well-being. Further, managerial implications have also been discussed. This study is conceptual in nature, which needs to be empirical tested.

***Keywords:*** *Physical Activity, Mental Well-Being*

*"To keep the body in good health is a duty…otherwise we shall not be able to keep our mind strong and clear."* ***- Buddha***

Due to past few decades, there has been an increasing attention on regular physical activity and exercise (Fletcher et al., 1996). Physical activity and exercise can be considered as the fundamental step in lifestyle modifications for the prevention of chronic diseases. Now-a-days, there has been growing focus on psychological well-being of such activities (Stathi et al., 2002), particularly in the domain of mental well-being. Regular physical activity can help to improve the mental well-being outcomes. Mental well-being outcomes include improvements in self-esteem, reduction in depressive symptoms, anxiety and emotional distress (Janssen and LeBlanc, 2010). Physical inactivity increases the risk of anxiety and stress level, which increases the mortality rates. Physical inactivity is the fourth foremost cause of death in the UK (Lee et al. 2012). In order to reduce the negative effects of physical activity like depression, anxiety and stress, focuses on motivating the entire ages group to participate in regular physical activity and exercise. It has also been observed that physical activity like aerobic exercises, which includes, running, swimming, walking, bicycling, dancing and doing jumping jacks helps to reduce the depression, anxiety and stress level. In the same vein, physical activities, especially aerobic exercise in small to medium sized groups, may have positive impacts on cognitive thinking. The

[1] Lecturer of Physical Education, GHSS, Katra, Vaishno Devi, J&K, India
*Responding Author

**Received: February 3, 2017; Revision Received: February 19, 2017; Accepted: February 25, 2017**

probable benefits of physical activity in terms of emotional, cognitive and social wellbeing receive relatively less attention. Based on extant review of literature, it has been found that most of the research studies have identified the relationship between physical activity and self-esteem (Gilani and Pour, 2016); physical activity and anxiety (Mochcovitch et al., 2016; Anderson and Shivakumar, 2013); physical activity and depression (component of mental health well-being) (Overdorf et al., 2016; Lee et al. 2014) but there is dearth of research regarding impact of physical activity on overall mental wellbeing. Therefore, the present study focuses on the prospective of physical activity to enhance our wellbeing. In particular, it concentrates on mental-health wellbeing.

***Physical Activity and Self-Esteem***

Self-esteem is considered as a term which is used in psychology that facilitates to express the degree to which individuals feel positive about themselves. It is an important aspect of mental health (Gilani and Pour, 2016). In other words, self-esteem enhances mental growth and also plays a vital role in an individual's thoughts, feelings, values, and goals. Ghafari et al. (2007) believed that people with higher levels of self-esteem appraise themselves positively and have an affirmative attitude toward themselves. Self-esteem is a vital aspect when studying mental well-being because of (a) its close relationship with emotional stability and adjustment, (b) low self-esteem deals with many forms of mental illness as well as is associated with poor health behaviours. Previous literature has suggested that several ways for improving self-esteem. One of them is physical activity, which helps us to attain a higher degree of mental and physical power. Erikssen et al. (1998) revealed that an individual's physical activities positively influences on his or her mental health. Various researchers such as Hansen et al. (2001) and Ghafar et al. (2007) revealed that physical activities are beneficial in the management of psychological issues, like anxiety, depression, anger, tension, reaction to stress, self-efficacy, and self-esteem. Sepahmansour et al. (2012) proved that physical activity and exercise positively influences on self-esteem. In this same line, physical activity and exercise improve an individual's adequacy and efficiency. Opdenacker et al. (2009) indicated that there is a positive correlation between physical activity and self-esteem in adults. Participation in physical activity and sports helps to improve the self-esteem of an individual. Physical activity and sports provides positive perception, which in turn create a feeling of competence and self-acceptance in individuals.

***Physical activity and depressive symptoms***

Depression refers to a major health problem in the world today (Overdorf et al., 2016). In other words, it is a chronic mental illness (Lee et al., 2014). The main characteristics of depression are loss of capacity to experience pleasure, increased sense of worthlessness, fatigue, and preoccupation with death and suicide (Neugebauer et al. 1999). Depressive symptoms are common in modern era. Physical activities or exercise might endow with an alternative to reduce depression or depressive symptoms. Hassmen et al. (2000) stated that high amount of physical

activities, low amount of depressive symptoms in adolescent and middle-aged populations. Physical activities might be effectively to reduce the depressive symptoms among patients with mild to moderate depression (Martinsen, 1994). King et al. (1993) stated that aerobic exercise play an essential role in reducing depressive symptoms only among men after a 16 week aerobic exercise program. Further, Lampinen et al. (2010) asserted that older women less engaged in physical activity program than the male counterparts. Less engaged in physical activity program, result in increase depressive symptoms. In the same vein, physical inactivity increases the risk of depression in our society. Additionally, physical inactivity has been widely recognised as one of the key risk factors in many chronic diseases such as cardio-vascular disease, Type II diabetes, as well as in mental health problems, especially depression (Blair and Brodney, 1999). Blumenthal et al. (1989) indicated that yoga and aerobic exercise reduced depressive symptoms.

***Physical activity on anxiety***

Anxiety refers to as a set of physiological and behavioural responses that protect individuals from danger. In clinical term, anxiety is also considered as an unpleasant, subjective state of vague and diffuse apprehension that is often accompanied by physical sensations, such as sweating, muscle tension, tremors, and tachycardia, among others (Mochcovitch et al., 2016). Adults who engage in regular physical activity occurrence fewer anxiety symptoms (van Minnen et al., 2010). The major anxiety disorders defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) are General Anxiety Disorder (GAD), Panic Disorder (PD), Posttraumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), Social Anxiety Disorder, and Specific Phobia (APA, 2000). Further, the occurrence of anxiety disorders in older adults is lower as compared to younger adults; many older adults report anxiety symptoms (Viana and Andrade, 2012). In this context, physical activities for younger adults are beneficial in both anxiety disorders and anxiety symptoms (Jayakody et al., 2014). Further, out of five meta-analyses, four concluded that exercise is an effective treatment for anxiety, with effect sizes ranging from 0.22 (small) to 0.56 (moderate) (Stonerock et al. 2015). Aerobic activities help to decrease in anxiety-related behaviour and sleep pattern improvements (Costa et al. 2012). Further, aerobic exercise is effective in reducing high sensitivity to anxiety such as the propensity to fear anxiety sensations based on appraisals that they will lead to disastrous consequences, an attribute which is characteristic of most anxiety disorders. Physical activity appears to be effective strategies to reduce the anxiety disorders in all ages. Zhang et al. (2014) indicated that different physical activities such as swimming, running, square dancing, tai chi, and a control group treat anxiety symptoms in older adults. Physical activities are considered as an effective tool for improving anxiety symptoms also in older populations (Mochcovitch et al., 2016).

## DISCUSSION AND CONCLUSION

The present study focuses on impact of physical activity on mental health wellbeing. Physical activity is an important tool in improving mental health well-being. Mental illness is socially

unbearable and allied with suicide ideation and attempts, drug and alcohol abuse and homelessness. In these cases, however, various individuals who suffer a general dissatisfaction of low mental well-being categorized by emotional distress, low self-esteem, sense of hopelessness, chronic stress and anxiety. In this situation, most of the individuals take heavy drinking, smoking, absenteeism from work, family breakdown, physical violence and abuse, and quality of life. In current era, these problems seem to be in westernized countries regardless of the stability of economic or political climate. In this regard, physical activity plays an important role to solve mental health related problems such as treatment of mental illness and disorders; prevention of mental illness and disorders; improvement of mental and physical well-being of those with mental illness; improvement of mental well-being of the general population. Further, physical activity is associated with decreased risk of depression. Experimental studies show that aerobic and resistance exercise is most efficient in treating depression. Fox (1999) revealed that physical activity and exercise can facilitate prevent and treat this common cause of mental illness and threat to mental well-being. Physical activity and exercise can be beneficial in treating and avoiding depressive illnesses, and it can also be used as a means of reducing stress and anxiety on a daily basis in order to improve mood and sleep quality, in this way, sense of mental well-being can be more positively. Physical activity refers to as a vehicle for improving self-perceptions, mood, life satisfaction, social interaction and quality of life in modern era. Further, Strohle (2009) stated that physical activity positively affects on mood and stress. Physical activity is often as an alternative approach to reducing or managing stress. It is seen as one of the most important element that protect against anxiety. Aldana et al. (1996) indicated that lower level of stress among physically active adults as compared to inactive ones. In the same vein, physical inactivity as a significant risk factor for mental disorders. In addition to this, physical activity may also strengthen the self-esteem among individuals. In this context, people who participate in physical activity have greater physical and overall self-esteem such as high life satisfaction, resilience and greater achievement in education and work. Physical activity plays an important role in promoting mental health. In other words, physical activity can develop psychological well-being, by improving self-perception and self-esteem, mood and sleep quality, and by reducing levels of anxiety and fatigue. The major implications of this study every individuals should be walk at least 45 to 60 minutes in each day towards this all truly great thoughts are conceived while walking. Further, each individual should be 10–15 minute period of rest in order to participants' moods returned towards calmness and relaxation and feel less depression. In short, physical activity could be used as a strategy to regulate mood during the entire day. Moreover, individuals should participate in physical activity that facilitates to increase positive health behaviours during periods of stress, for instances, decreased smoking and healthier eating habits. Individuals' preferences about physical activity type like swimming, dancing, and football should be accommodated into physical activity programmes. In competitive environment, people less participate in physical activity, every individual should be motivate at least 45-60 minutes participate in physical activity in order to reduce the anxiety and stress. Physically active employees tend to have greater job satisfaction, higher mental alertness

and higher self-confidence. Employees should be encouraged to use stairs instead of lift that facilitate to feel physically fit as well as employers arrange on-site gym or discount at a local leisure facility in order to employees to become active during their break and before and after work. Employers should also organize group activities such as yoga, which can also increase activity level and reduce the anxiety level of employees. Lastly, all health practitioners should be encouraged to become physically active themselves, both for their personal self-care as well as role models. Few limitations of this study need to be acknowledged. First, this study focuses only two variables i.e. physical activity and mental health, physical health should be considered in future. Secondly, this study is conceptual in nature; empirical study should be conducted in future in order to improve the generalisability of the findings.

***Acknowledgments***

The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Aldana, S. G., Sutton, L. D., Jacobson, B. H., & Quirk, G. (1996). Relationships between leisure time physical activity and perceived stress. *Perceptual and Motor Skills, 82* (1), 315–321.

Anderson, E., & Shivakumar, G. (2013). Effects of exercise and physical activity on anxiety. *Frontiers in Psychiatry, 4*, 1-4.

Blair, S., & Brodney, S. (1999). Effects of physical activity and obesity on morbidity and mortality: Current evidence and research. *Medical Science and Sports Exercise, 31*, 646-662.

Blumenthal, J. A., Babyak, M. A., Moore, K. A., Craighead, W. E., Herman, S., Khatri, P., & Krishnan, K. R. (1999). Effects of exercise training on older patients with major depression. *Archives of Physical Medicine and Rehabilitation, 159*, 2346-2349.

Costa, M. S., Ardais, A. P., Fioreze, G. T., Mioranzza, S., Botton, P. H, Portela, L. V., Porciuncula, L. O. (2012). Treadmill running frequency on anxiety and hippocampal adenosine receptors density in adult and middle-aged rats. *Progress in Neuro-Psychopharmacology & Biological Psychiatry, 36* (1),198-204.

Erikssen, G., Liestol, K., Bjornholt, J., Thaulow, E., Sandvik, L., & Erikssen, J. (1998). Changes in physical fitness and changes in mortality. *Lancet, 352* (9130), 759–62.

Fletcher, G. F., Balady, G., Blair, S. N., Blumenthal J., Caspersen, C., Chaitman, B., ..... Pollock, M. L. (1996). Statement on exercise: Benefits and recommendations for physical activity programs for all Americans. A statement for health professionals by the Committee on Exercise and Cardiac Rehabilitation of the Council on Clinical Cardiology. *Circulation, 94* (4), 857-862.

Fox, K. R. (1999). The influence of physical activity on mental well-being. *Public Health Nutrition, 2* (3a), 411–418

Ghafari, F. F. Z., & Mazloom, S. R. (2007). The effects of groups regular training on self-esteem in nurse student. *Medical Sciences Babol Univiversity Journal, 9* (1):52–57.

Gilani, S. R. M., & Pour, A. D. (2016). The effects of physical activity on self-esteem: A comparative study. *International Journal of High Risk Behaviour Addiction*, 1-6. doi: 10.5812/ijhrba.35955.

Hansen, C. J., Stevens, L. C., & Coast, J. R. (2001). Exercise duration and mood state: How much is enough to feel better?. *Health Psychology, 20* (4), 267-275.

Hassmen, P., Koivula, N., & Uutela, A. (2000). Physical exercise and psychological well-being. *Preventive Medicine, 30*, 17-25.

Janssen, L., & d LeBlan, A. G. (2010). Review systematic review of the health benefits of physical activity and fitness in school-aged children and youth. *International Journal of Behavioral Nutrition and Physical Activity, 7* (40), 1-16.

Jayakody, K., Gunadasa, S., & Hosker, C. (2014). Exercise for anxiety disorders: Systematic review. *British Journal of Sports Medicine, 48*, 187-96.

King, A. C., Taylor, C. B, & Haskell, W. L. (1993). Effects of differing intensities and formats of 12 months of exercise training on psychological outcomes in older adults. *Health Psychology, 12*, 292–300.

Lampinen, P., Heikkinen, R. L., & Ruoppila, I. (2000). Changes in intensity of physical exercise as predictors of depressive symptoms among older adults: An eight-year follow-up. *Preventive Medicine, 30*, 371-380.

Lee, H., Lee, J. A., Brar, J. S., Rush, E. B., & Jolley, C. J. (2014). Physical activity and depressive symptoms in older adults. *Geriatric Nursing, 35*, 37-41.

Lee, H., Cardinal, B. J., & Loprinzi, P. D. (2012). Effects of socioeconomic status and acculturation on accelerometer-measured moderate-to-vigorous physical activity among Mexican American adolescents: Findings from NHANES 2003–2004. *Journal of Physical Activity and Health, 9* (8), 1155-1162.

Martinsen, E. W. (1994). Physical activity and depression: Clinical experience. *Acta Psychiatrica Scandinavica, 89* (377), 23–27.

Mochcovitch, M. D., Deslandes, A. C., Freire, R. C., Garcia, R. F., & Nardi, A. E. (2016). The effects of regular physical activity on anxiety symptoms in healthy older adults: A systematic review. *Revista Brasileira de Psiquiatria, 38*, 255-261.

Neugebauer, R. (1999). Mind matters: The importance of mental disorders in public health's 21st century mission. *American Journal of Public Health, 89*,1309–1311.

Opdenacker, J., Delecluse, C., & Boen, F. (2009). The longitudinal effects of a lifestyle physical activity intervention and a structured exercise intervention on physical self-perceptions and self-esteem in older adults. *Journal of Sport and Exercise Psychology, 31*(6), 743–60.

Overdorf, V., Kollia, B., Makarec, K., & Szeles, C. A. (2016). The relationship between physical activity and depressive symptoms in healthy older women. *Gerontology and Geriatric Medicine, 2*, 1–8.

Sepahmansour, M., Memar, A., & Azmodeh, M. (2012). The relationship of the self-esteem and self-efficacy with persuasion in training managers. *Social cognition, 1* (2), 92-100.

Stathi, A., Fox, K. R., & James, M. (2002). Physical activity and dimensions of subjective wellbeing in older adults. *Journal of Aging and Physical Activity, 10* (1), 76–92.

Stonerock, G. L., Hoffman, B. M., Smith, P. J., Blumenthal, J. A. (2015). Exercise as treatment for anxiety: Systematic review and analysis. *Annals of Behavioral Medicine, 49,* 542-56.

Strohle, A. (2009). Physical activity, exercise, depression and anxiety disorders. *Journal of Neural Transmission, 116* (6), 777–784.

Van Minnen, A., Hendriks, L., & Olff, M. (2010). When do trauma experts choose exposure therapy for PTSD patients? A controlled study of therapist and patient factors. *Behaviour Research and Theraphy, 48*, 312–320.

Viana, M. C., & Andrade, L. H. (2012). Lifetime prevalence, age and gender distribution and age-of-onset of psychiatric disorders in the Sao Paulo Metropolitan Area, Brazil: Results from the Sao Paulo Megacity Mental Health Survey. *Revista Brasileira de Psiquiatria, 34*, 249-60.

Zhang, X., Ni, X., & Chen, P. (2014). Study about the effects of different fitness sports on cognitive function and emotion of the aged. *Cell Biochemistry and Biophysics,70*,1591-1596.

**How to cite this article:** Kumar R (2017), Role of Physical Activity in Mental Well-Being, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.111/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.112/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Relationship of Parental Burnout with Parental Stress and Personality among Parents of Neonates with Hyperbilirubinemia

Prof. Seema Vinayak[1]*, Simplejit Kaur Dhanoa[2]

**ABSTRACT**

This study was designed to examine the inter-relationships between parental burnout, personality and parental stress among mothers as well as fathers of children with neonatal jaundice. The sample comprised with 200 parents, which were further divided into 100 parents of male neonates (i.e. 50 fathers and 50 mothers), 100 parents of female neonates (i.e. 50 fathers and 50 mothers). The results showed that the relationship exists between parental burnout, personality and parental stress among all the groups.

***Keywords:*** *Hyperbilirubinemia, Parental Burnout, Neonates*

**N**eonates with hyperbilirubinemia are on higher risk of being diagnosed with autism or some other psychological development disorder later on in life compared to infants who did not have neonatal jaundice (Radha et al., 2012). The child with developmental delays may disrupt family routines, may require extra care, and create new stress in family relationships (Gray, 2003). Neonate with hyperbilirubinemia may cause a financial strain on family for medical specialists and for treatment. Since caring a sick neonate is demanding and difficult and requires additional effort, it is not surprising that parents of neonates with hyperbilirubinemia have reported the greatest levels of stress as compared to neonates without hyperbilirubinemia (Boyd, 2002; Herring et al., 2006).

The theoretical models of parental burnout have focused on two major sources. The first source is the well-known care giving and stress process model by Pearlin et al. (1990) that identifies stressors and role strains often encountered by caregivers who may lead to negative outcomes such as anxiety, depression, cognitive disturbances and problems with physical health. The second source is a model by Platt, Weyman, Hirsch & Hewett (1980) that identifies a range of problematic behaviors and impaired functional abilities that have been linked to negative

[1] Professor Dept. of Psychology, Panjab University, Chandigarh, India
[2] Ph. D Scholar, Dept. of Psychology, Panjab University, Chandigarh, India
*Responding Author

**Received: January 17, 2017; Revision Received: February 19, 2017; Accepted: February 25, 2017**

outcomes for the family members and friends. The primary stressors noted in the model include patient symptoms, disruptive patient behaviors, impaired patient role performance, issues of dependency, caregiver role overload/burnout and caregiver relational deprivation and their personality. Secondary stressors include family conflict, care giving/role conflict, caregiver concerns about the future, constriction of caregiver social activities and economic problems.

Parental burnout is a state of physical, emotional and mental exhaustion that may be accompanied by a change in attitude from positive to negative (Luecher et al., 1999). Burnout can occur when caregivers don't get the help they need either physically or financially. Parents who are "burn out" may experience fatigue, stress, anxiety and depression (Kasuya et al., 2010). Parents often are so busy caring for others that they tend to neglect their own emotional, physical and spiritual health. The demands on a caregiver's body, mind and emotions can easily seem overwhelming, leading to fatigue, hopelessness and ultimately burnout. Other factors that can lead to parental burnout may include role confusion, unrealistic expectations, lack of control and unreasonable demands. Considering the seriousness of the physical exhaustion syndrome, it is most important to identify parents with burnout symptoms as early as possible. In addition, psychological reactions may affect the parent's ability to manage the child's treatment and also influence the child's development (Lindstrom et al., 2009).

Parental stress is a specific kind of stress perceived by parent and emanating from the demands of being a parent (Berry & Jones, 1995). Parental stress is a complex construct that involves behavioral, cognitive and affective components. It is a combination of child and parents characteristics as well as family situational components as they relate to the person's appraisal of his or her role as a parent (Herring et al., 2006). Parental stress has been described as the difficulty that a parent feels or experiences while watching their children in pain. Parental stress consists of parent related variables (e.g. parent psychological wellbeing), child related variables (e.g. child characteristics) and negative life events (Rondo et al., 2003). Duygun & Sezgin (2003) reported that parental burnout occurs with persisting demands of the family's needs. These persisting demands deplete the motivation of the parents and they may experience the emotions of self-blame and anger. Caregiver burnout is the final step in the progression of caregiver burden/stress, where the experience is no longer healthy for both the caregiver and the person receiving care.

Personality is the particular combination of emotional and behavioral response patterns of an individual. Personality refers to the organized pattern of behavioural characteristics that are the working result of the distinguishing physical, mental, emotional and social features of an individual person (Digman, 1990). According to McCrae & Costa (1992) Personality is usually broken into components called the Big Five, which are openness to experience (degree of intellectual curiosity, preference for novelty), conscientiousness (self-disciplined, planned and

organized), extroversion (positive emotions, assertiveness and sociability), agreeableness (compassionate and cooperative) and neuroticism (experience unpleasant situation easily). These components are generally stable over time and appear to be attributable to a person's genetics rather than the effects of one's environment. Buhler et al. and Lingard (2003) found that extraversion is negatively associated with emotional exhaustion. Francis et al. (2004) and Zellars et al. (2000) found a negative association between extraversion and depersonalization Rossler et al. (2013) studied association between burnout and personality among the general population. The results identified a complex interaction between maladaptive personality and burnout.

***The aim of this study is to examine***

1. The relationship of parental stress, personality with burnout of the parents of neonates with hyperbilirubinemia.
2. The parental stress in parents of male and female neonates with hyperbilirubinemia.
3. The personality of parents of male and female neonates with hyperbilirubinemia.

***Hypotheses***

1. It is expected that there will be a positive relationship of parental burnout with
   a. parental stress
   b. personality viz. neuroticism
2. It is expected that there will be a negative relationship of parental burnout with
   a. personality viz. extraversion, openness, agreeableness and conscientiousness.

***Design***

This study has been designed to examine the inter-relationships of parental burnout with parental stress and personality among mothers as well as fathers of neonates with hyperbilirubinemia. The sample comprised of 300 parents, in the age range of 20-35 years. The sample was further divided into 100 parents of male neonates with hyperbilirubinemia (i.e. 50 fathers & 50 mothers) and 100 parents of female neonates with hyperbilirubinemia (i.e. 50 fathers & 50 mothers). The findings of the study revealed that there is relationship among parental burnout, parental stress and personality. Parents of neonates having bilirubin level 17mg/dl to 24mg/dl and have preterm first live bon baby with gestational age between 35to 38 weeks were included. Parents with educational qualification at least higher secondary and belonging to middle socio economic status were taken. Mothers who were non-working and parents belongs to nuclear family were included in this study.

***Tests and Tools***

The following standardized tests and tools would be used to collect the data:

1. **Maslach Burnout Inventory (MBI):**

MBI is a **22-item** instrument developed by **Maslach & Jackson (1986)** to assess the three components of the burnout syndrome:

*(a) Emotional Exhaustion,* measures feelings of being emotionally overextended and exhausted by one's work.

*(b) Depersonalization* measures an unfeeling and impersonal response towards recipients of one's service, care treatment or instructions *and*

*(c) Lack of Personal Accomplishment,* measures feelings of competence and successful achievement in one's work.

The respondents answer the statements about personal feelings or attitudes in terms of how frequently they experienced the stated situation on a 7-point scale. It is adapted and translated by Ergin (1992), and the 7-point scale was converted into a 5-point scale (0=never; 4=always). Duygun & Sezgin (2003), changed the instructions of the questionnaire into "my child" instead of "my recipients" and "the care of my child" instead of "my work" or "my job". Duygun & Sezgin (2003), found that the MBI had two factors in a sample of mothers who had mentally retarded children. In his study, the Cronbach Alpha values were .80 for both emotional exhaustion and lack of personal accomplishment factors. In the present study, the alpha values were .87 for emotional exhaustion, .74 for lack of personal accomplishment and .85 for total burnout scale.

**2. The Parental Stress Scale (PSS):**

This scale was developed by **Berry & Jones, 1995**. The PSS is a self-report scale that contains 18 items representing pleasure or positive themes of parenthood (emotional benefits, self-enrichment, personal development) and negative components (demands on resources, opportunity costs and restrictions). Respondents are asked to agree or disagree with items in terms of their typical relationship with their child or children and to rate each item on a five-point scale: strongly disagree (1), disagree (2), undecided (3), agree (4), and strongly agree (5). The 8 positive items are reverse scored so that possible scores on the scale can range between 18-90. Higher scores on the scale indicate greater stress. The scale is intended to be used for the assessment of parental stress for both mothers and fathers and for parents of children with and without clinical problems. The scale demonstrated satisfactory levels of internal reliability (.83), and test-retest reliability (.81). The scale demonstrated satisfactory convergent validity with various measures of stress, emotion and role satisfaction including perceived stress, work/family stress, loneliness, anxiety, guilt, marital satisfaction, marital commitment, job satisfaction and social support. Discriminant analyses demonstrated the ability of the scale to discriminate between parents of typically developing children and parents of children with both developmental and behavioral problems.

**3. NEO-Personality Inventory (Big-5):**

Big-5 was developed by **Costa & McCrae, 1985**. Big five is a self report inventory of 44 items. It designed to measure big five personality dimensions. Each of the factors is further

divided into personality facets: OCEAN; *Openness, Conscientiousness, extraversion, Agreeableness and Neuroticism*. It represents a biological account of personality traits as well as environmental influences, such as social roles combines with biological influences in shaping personality traits.

(a) The *Openness* means people who like to learn new things and enjoy new experiences usually score high in openness. It includes traits like being insightful, imaginative, lives in fantasies and having vided variety of interests.

(b) The *Conscientiousness* means people that have a high degree of conscientiousness are reliable and prompt. Traits include being organized, methodical, competence, order, dutifulness, achievement striving, self discipline and deliberation.

(c) The *Extraversion;* extraverts get energy from interacting with others, while introverts get energy from within themselves. Extraversion includes the traits of sociable, energetic, assignment seeking, assertiveness, positive emotions and warmth.

(d) The *Agreeableness*, these individuals are friendly, cooperative and compassionate, traits include being kind, affectionate, sympathetic, forgiving, not demanding, warm, compliance, tender mindedness and modesty.

(e) The *Neuroticism* is also sometimes called emotional stability. This dimension relates to one's emotional stability and degree of negative emotions. The traits include being moody, tense, anxiety, anger hostility, depression, self consciousness, Impulsiveness and vulnerability. The internal reliability range between .87 to .92.

***Statistical Analysis***

To meet the objectives of the study, descriptive statistics viz. mean, Standard Deviation, correlation will be studied.

## RESULTS

***Table 1: Shows the Correlation of Parental Burnout with Parental Stress and Dimensions of Personality***

| Parental Burnout | Parental Stress | Extraversion | Agreeabl-eness | Conscietious-ness | Openness | Neuroticism |
|---|---|---|---|---|---|---|
| 1 | .412** | -.398** | -.044 | -.102 | -.275* | .332** |

*P<_.05* and .01***

***Table 2: Shows the Correlation between Parental Burnout, Parental stress and Personality among Parents of Female neonates with neonatal Hyperbilirubinemia***

| Parental Burnout | Parental Stress | Extraversion | Agreeable ness | Conscietious ness | Openness | Neuroticism |
|---|---|---|---|---|---|---|
| 1 | .392** | -.251* | -.001 | -.101 | -.211* | .300** |

*P<_.05* and .01***

***Table 3: Shows the Correlation between Parental Burnout, Parental stress and Personality among Parents of Male neonates with neonatal Hyperbilirubinemia***

| Parental Burnout | Parental Stress | Extraversion | Agreeableness | Conscietiousness | Openness | Neuroticism |
|---|---|---|---|---|---|---|
| 1 | .255* | -.242* | -.010 | -.031 | -.001 | .298* |

*P<_.05* and .01***

## DISCUSSION

The aim of the present investigation was to study the relationship of parental burnout with parental stress and personality among parents of neonates with hyperbilirubinemia. The sample was categorized into parents of male and female neonates with hyperbilirubinemia.

For the present investigation purposive sample was comprise of 200 parents, in the age range of 20-35 years because we are taking the sample of first live born neonates with hyperbilirubinemia from the clinical setting. The sample was further divided into 100 parents of male neonates with hyperbilirubinemia (i.e. 50 fathers & 50 mothers) and 100 parents of female neonates with hyperbilirubinemia (i.e. 50 fathers & 50 mothers).

Those parents whose child was preterm with more than 17mg/dl bilirubin level and with educational qualification of at least higher secondary level were included. The sample were taken from the government and private hospitals of Chandigarh as most of the patients from Punjab, Haryana and nearby areas come for the treatment of hyperbilirubinemia and also for the follow ups of the children.

Scoring for all the given tests was done as per the instructions provided in the scoring manuals of the tests. Normality of the data was assessed before conducting the statistical analysis. Correlation analysis was conducted to find out relationship of various variables with parental burnout. All groups were assessed on parental stress and on personality and their role with parental burnout.

The results showed positive inter-correlation between parental burnout and parental stress among all the groups and several studies supported the results. Stress among parents of disabled children and neurotic children undergo more stressful experiences. The care giving of severely ill children is so stressful that accompanied with burnout. The studies show positive correlation between parental stress and parental burnout (Gupta & kaur, 2010; Faber et al., 2002; Hidangyum, 2010). The positive relationship revealed between the parental burden, social emotional burden, disruption of family routine and disturbance in family interactions among parents of intellectually disabled children (Seshadri et al., 2000). Giving birth to a mentally challenged or other critically ill child is an unexpected stressful event which affects the parents. Such an event may impair family development and may continue over time, affecting the entire family system.

The impact of illness is associated with emotional and psychological stress and parents may face frequent fear, confusion, stigma and isolation which is correlated with parental burnout and burden (Hindmayum, 2010). Several studies showed (Barakat et al., 2006; Buchi et al., 2007; Engelkemayer & Mewit, 2008; Hungerbuehler et al., 2011), that mothers report higher levels of growth than fathers (Barr, 2011; Buchi et al., 2007; Hungerbuehler et al., 2011) and that increasing seriousness of the potentially traumatizing event is related to higher PTG (Colville, 2009). The association also seems to be moderated by gender (Barakat et al., 2006).

Similarly, the findings of this study showed neuroticism and parental burnout are significantly positively correlated with among all the groups, hence, hypothesis (H1b) is significantly proved. Similarly, Extraversion and parental burnout are also significantly negatively correlated among all the groups. Openness to experience was significantly negatively correlated with parental burnout among total sample of parents and among parents of female neonates.

Most of the researches shows supporting role and revealed that burnout can be found both within and outside the human (Bakker, Demerouti & Schaufeli, 2002), Caregivers of severely ill children are generally at relatively high risk for burnout (Schaufeli, 2003). Caregiver's oftenly confronted with emotionally demanding relationships with the recipients of their care. Such relationships are inherently difficult and upsetting because caregivers have to deal with sufferer as well as with the society. Neuroticism is significantly correlated with parental burnout among the caregivers of patients in metropolitan hospitals (Fancis et al., 2010, 2003). Studies reported social extraversion and action extraversion to be negatively associated with burnout (Francis et al., 2013 & Zellars et al, 2000). A negative association was found between extraversion and parental burnout among caregivers of patients (Fancis et al, 2010; zellas et al., 2000; Buhler & Land, 1996). Indeed, (Lingard, 2003) reported social extraversion and action extraversion to be negatively associated with burnout. Researchers (e.g., Deary et al., 1996; Hills & Norvell, 1991; Lepine, Lepine, & Jackson, 2004; Lingard, 2003; Zellars et al., 2000) on the relationship between neuroticism and burnout have typically shown that individuals who are high in neuroticism are more likely to report feelings of emotional exhaustion and to report lower levels of personal achievement. In a study of intensive-care nursing staff (Buhler & Land, 2014) found that individuals who were higher in neuroticism experienced higher levels of emotional exhaustion and depersonalization. However, (Deary et al., 2003) noted a significant association between neuroticism at and emotional exhaustion among nursing students.

## CONCLUSION

Parental Burnout occurs with persisting demands and these persisting demands deplete the motivation of the caregivers and they experience emotions of self blame. Here, personality plays a vital role in the development of burnout. Neurotistic persons are more prone towards stress and they have less coping abilities to deal with stressful situation while the other four dimensions

personality can easily cope with trauma and may try to adjust and cope with the situation. So, the caregivers need special counselling sessions as well as the sessions to deal with and to manage with stressful situations especially during the hospitalization of their children.

***Acknowledgments***

The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Almberg, B., Grafstrom, M., Krichbaum, K., & Winblad, B. (2000). The interplay of institution and family caregiving: Relations between patient hassles, nursing home hassles and caregivers' burnout. *International Journal of Geriatric Psychiatry*, 15, 931-939.

American Academy of Pediatrics. (1995). Practice parameter: Management of hyperbilirubinemia in the healthy term newborn. *Journal of Pediatrics*, 95, 458–461.

Arnold, B. B., Kareni, V. D., Kerrya, L., & Maureen, F. D. (2002). The relationship between the big five personality factors and burnout: A study among volunteer counselors. *Journal of Social Psychology*, 135, 456-68.

Berry, J. O., & Jones, W. H. (1995). The parental stress scale: Initial psychometric evidence. *Journal of Social and Personal Relationships*, 12, 463-472.

Blumberg, N. L. (1980). Effects of neonatal risk, maternal attitude and cognitive style on early post-partum adjustment. *Journal on Abnormal Child Psychology*, 89, 139-150.

Boyd, B. A. (2002). Examining the relationship between stress and lack of social support in mothers of children with autism: Focus on autism & other developmental disabilities. *Journal of Child Psychology*, 17, 208-215.

Brandson, D. H., Tully, K. P., Silva, S. G., Makolm, W. F., Turner, B. S., & Davis, D. H. (2011). Emotional responses of mothers of late preterm and term infants. *Journal of Obstetric, Gynecologic and Neonatal Nurses Issues*, 40, 719-731. doi:10.1111/j.1552-6909.2011.01290.x

Buhler, K. E., & Land, T. (2003). Burnout and personality in intensive care: An empirical study. *Hospital Topics: Research and Perspectives on Health Care*, 81, 5–12.

Bystrova, K., & Ivanova, V. (2009). Early contact versus separation: effects on mother infant interaction one year later. *Journal of Pediatrics*, 36, 97-109.

Cadell, S., Regeur, C., & Hemsworth, D. (2003). Factors contributing to posttraumatic growth: A proposed structural equation modeling. *Anniversary Journal of Orthopsychiatry*, 73, 279-287.

Calhoun, L. G., Cann, A., Tedeschi, R. G., & McMillan, J. (2000). A correlational test of the relationship between posttraumatic growth, religion and cognitive processing. *Journal of Traumatic Stress*, 13, 521-527.

Calhoun, L. G., & Tedeschi, R. G. (1999). Facilitating posttraumatic growth: A clinician's guide. Mahwah, NJ: Erlbaum.

Carol, R., Donal, G., Fortune, & Prentice, G., (2013). Post-traumatic growth, illness perceptions and coping in people with acquired brain injury. *Neuropsychological Rehabilitation: An International Journal*, 78, 639-657. doi: 10.1080/09602011.2013.799076.

Catz, C., Hanson, J., Simpson, L., & Yaffe, S. (1995). Summary of workshop: early discharge and neonatal hyperbilirubinemia. *Journal of Pediatrics*, 96, 743-45.

Christian, N. (2010). Infant jaundice linked to higher risk of autism and psychological development disorders. *Journal of Pediatrics*, 80, 456-75.

Crnic, K. A., & Booth, C. L. (1991). Mothers' and fathers' perceptions of daily hassles of parenting across early childhood. *Journal of Marriage and the Family*, 53, 1042-1050.

DeMier, R. L., Hynan, M. T., Hatfield, R. F., & Maniello, R. L. (2000). A measurement model of perinatal stressors: identifying risk for postnatal emotional distress in mothers of high-risk infants. *Journal of Clinical Psychology*, 56, 89-100.

Duygun, T., & Sezgin, N. (2003). The effects of stress symptoms, coping styles and perceived social support on burnout level of mentally handicapped and healthy children's mothers. *American Journal on Mental Retardation*, 18, 37-52.

Engelkemeyer, S. M., & Marwit, S. J. ( 2008). Posttraumatic growth in bereaved parents. J*ournal of Traumatic Stress*, 21, 344-346.

Francis, L. J., Louden, S. H., & Rutledge, C. J. F. (2004). Burnout among Roman Catholic parochial clergy in England and Wales: Myth or Reality?. *Review of Religious Research*, 46, 5–19.

Gray, D. (2003). Gender and Coping: The parents of children with high functioning autism. *Social Science Medicine*, 56, 631-642.

Gallagher, S., & Whiteley, J. (2012). The association between stress and physical health in parents caring for children with intellectual disabilities is moderated by children's challenging behaviour. *Journal of Psychiatry*, 45, 571-82.

Herring, S., Gray, K., Taffe, J., Tonge, B., Sweeney, D., & Einfeld, S. (2006). Behavior and emotional problems in toddlers with pervasive developmental disorders and developmental delay: Associations with parental mental health and family functioning. *Journal of Intellectual Disability Research*, 50,874–882.

Jennifer, L., Callahan, M. S., & Michael, T. (2009). Identifying mothers at risk for postnatal emotional distress: Further evidence for the validity of the perinatal posttraumatic stress disorder questionnaire. *Journal of Perinitology*, 22, 448-456.

Karanci, N. A., Alkan, N., Sucuolu, H., & Balta, E. (1999). Gender differences among parents of autistic children in psychological distress, coping, social support and related variables to burnout. *North American Journal of Psychology*, 1, 189-204.

Kasuya, R. T., Bailey, P., & Takeuchi, R. (2010). Caregiver burden and burnout. *Postgraduate Medicine*, 108, 119-123.

Kwan, M. Y. (2012). Parental stress in parents of children with disabilities. *Journal of Psychiatry*,2,11-21.

Lindstrom, C., Aman, J., & Norberg, A. (2009). Increased prevalence of burnout symptoms in parents of chronically ill children. *Journal of Pediatrics*, 99,427-437, doi: 10.1111/j.1651-2227.2009.01586.x

Lindstrom, C., Aman, J., & Norberg, A. L. (2011). Parental burnout in relation to sociodemographic, psychosocial and personality factors as well as disease duration and glycaemic control in children with type 1 diabetes mellitus. *Journal of Pediatrics*, 100, 1011-7. doi: 10.1111/j.1651-2227.2011.02198.x

Luecher, J. L., Dede, D. E., Giten, J. C., Fennel, E., & Maria, B. L. (1999). Parental burden, coping and family functioning in primary caregivers of children with joubert syndrome.

*Journal of Child Neurology*, 14, 642-648.

Patricia, R., Hannon, M. D., Sharla, K., Willis, & Susan, C. (2001). Persistence of maternal concerns surrounding neonatal jaundice. An Exploratory Study. *Archives Pediatrics Adolescent Medicine,* 155(12), 1357-1363. doi:10.1001/archpedi.155.12.1357.

Radha, L., Jaiswal, A., Reddy, P., & Srinivas, M. (2012). Predictors of significant jaundice in late preterm infants in India. *Indian Pediatrics,* 49, 717-720. SII:S097475591100553-1.

Rondo, P., Ferreira, R. F., & Nogueira, F. (2003). Maternal psychological stress and distress as predictor of low birth weight. *European Journal of Clinical Nutrition*, 57, 266- 72.

Rossler, W., Hengartner, M. P., Ajdacic, G. V., & Angst, J. (2013). Association between burnout and personality: results of the Zurich study. *Journal of Psychiatry,* 84,799-805. doi: 10.1007/s00115-013-3742-7.

Schaufeli, W. B., & Enzmann, D. (1998). The burnout campanion to study and practice: A critical analysis. London: Taylor and Francis.

Schoulte, J., Sussman, Z., Tallman, B., Comick, C., & Altmaier, E. (2012). Is there growth in grief: measuring posttraumatic growth in the grief response. *Journal of Medicine and Healthcare*,1, 38-43. doi:10.4236/oimp.2012.13007.

Smith, B. W., Dalen, J., Bernard, J. F., & Baumgartner, K. B. (2010). Posttraumatic growth in non-hispanic white and hispanic women with cervical cancer. *Journal of Psychosocial Oncolology*, 26, 91–109. doi: 10.1080/07347330802359768.

Smith, D., Fowler, J., DuBose, L., Saxton, D., & Herbert, J. (2013). An osteopathic approach to reduction of readmissions for neonatal jaundice. *Osteopathic Family Physician,* 5, 57-65. doi:10.1016/j.osfp.2012.09.005.

Zellars, K. L., Perrewe, P. L., & Hochwarter, W. A. (2000). Burnout in health care: The role of the five factors of personality. *Journal of Applied Social Psychology*, 30(8), 1570-1598.

**How to cite this article:** Vinayak S, Dhanoa S (2017), Relationship of Parental Burnout with Parental Stress and Personality among Parents of Neonates with Hyperbilirubinemia, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.112/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.113/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Participative Appreciative Therapy: A Positive Intervention Approach to Mental Health

Prof. (Dr.) Manju Agrawal[1]*

**ABSTRACT**

The paper introduces a positive psychotherapy called Participative Appreciative Therapy® (PAT). It is based on principals of Appreciative Inquiry combined with the power of visualization. It has two phases. Phase one is called CREAM having five components and phases two is called DESERT having six stages. The five components of CREAM phase are Catharsis, Rapport building, Empathy, Affirmative Topic and Motivational environment and the six stages of DESERT phase are Discovery, Exploring the Dream, Seeing the dream implemented, Emotional Glue, Representative actions and behaviour, Transformation and discussion. It can also be called Cream and Dessert Therapy. The most significant aspect of the therapy is positive outcomes are visible from the very first session as probing and inquiry are in themselves therapeutic because of its nature of setting goal and asking questions. Secondly development of insight for solutions is fast. PAT is actually not just a therapy but should actually be adopted as a lifestyle.

***Keywords:*** *Appreciative Inquiry, Cream and Desert Therapy, Participative Appreciative Therapy (PAT), Positive Psychotherapy, Affirmative Topic, Positive Therapeutic Goal, Discover and Dream, Emotional glue, Visualization, Positive Goal*

After World War II Psychology can largely be considered as a science about identification and treatment of diseases and problems. It largely concentrated on repairing damages with a disease model of human functioning. Attention to pathology neglected the fulfilled individual and the thriving community. This exclusive focus resulted in a model of human being lacking positive features that make life worth living. With the advent of Positive Psychology, the lopsided view of psychology shifted from human weaknesses to human strengths. Positive Psychology aims to catalyze a change in focus of psychology from preoccupation only with repairing the worst things in life to building positive qualities (Seligman and _Csikszentmihalyi 2000).

[1] Director, Amity Institute of Behavioral and Allied Sciences, Amity University, India
*Responding Author

**Received: November 15, 2016; Revision Received: February 19, 2017; Accepted: February 25, 2017**

Several core tenets of positive psychology. These tenets include a focus on positive traits, positive subjective experiences, and positive institutions. Positive psychology seeks "to find and nurture genius and talent", and "to make normal life more fulfilling" (Seligman, 2000).

Working on patients of Myocardial Infarction (Agrawal et.al. 1995) introduced the term "**Positive Life Orientation" (PLO).** In the longitudinal study the relationship was investigated between PLO and both perceived and medical recovery from a recent myocardial infarction (MI), i.e. heart attack. PLO was defined as a predisposition to selectively focus one's attention on the brighter side of any situation. Results showed positive correlation of patients' PLO scores with their medical recovery, perceived recovery, expected recovery, personal control and mood state but negative with helplessness. Significant correlations among variables under the study often reduced to insignificance on partialing out PLO. PLO thus emerged as an important factor in recovery from MI (Agrawal et.al., 1995). Studies have shown that optimism is associated with problem focused coping, active seeking social support, laying emphasis on positive aspects of illness, as well as greater acceptance of uncontrollable outcomes ( Burish and Bradley 1983; Scheier and Carver 1985). Several researches suggested that pessimistic explanatory style leads to helplessness, which in turn results in passivity, depression, poor problem solving, low self esteem, poor immune functioning, and higher morbidity (Peterson et.al., 1988; Kamen et.al.1987; Peterson, 1988). Other researchers have also shown desirable consequences of positive thinking on one's coping and performance (Peterson and Barrett, 1987; Seligman and Schulman, 1986). In a study on recovery from MI was associated with a belief in a just world and a belief that recovery from disease is in their control (Agrawal and Dalal, 1993). Positive attitude have a long-standing impact on prognosis in old age (Pitkala et.al, 2004) Positive life orientation is an important inner health resource for older (Fagerström, 2010). Dalal and Singh (1992) also found perceived control over the chronic disease to be linked with better adjustment. A number of studies suggest that people do search for the causes of negative and unexpected outcomes (Weiner, 1985; Wong and Weiner, 1981). In a study by Greenberg et al. (1984). Abramson et al. (1978) and Miller and Norman (1979) postulated that helplessness would occur when people perceive the undesirable event as uncontrollable and attribute it to stable-internal causes (e.g., weak constitution). Hence it may be said that a belief that patient can control the course of one's own disease or the events in future can develop learned optimism a term used by Carr (2004).

Working on his own experiences of recovery from an irreversible disease Norman Cousins (1983), now a faculty member at UCLA School of Medicine suggested that beyond the central nervous system, hormonal system and Immune system there are two other systems: the healing system and the belief system which help a person recover fast from even irreversible diseases. The healing system is the way the body mobilizes all its resources to combat disease. The belief system is often the activator of the healing system (Cousins; 1983). He healed himself from irrevocable disease through these systems. These systems recognize that hope, faith, love, will to

live, cheerfulness, creativity, playfulness, confidence and great expectations have great therapeutic value. Yet, till now, most of the traditional therapies take pathology focused and problem focused approach neglecting these positive systems inbuilt in human body itself.

Recognizing the need for developing and strengthening the positive belief systems for better emotional adjustment and coping, the present paper presents a Positive Psychotherapy "Participative Appreciative Therapy" (PAT). It is based on fundamentals of positive psychology, the research experiences and therapy experiences of the author of inculcating positive life orientation among patients and their recovery process from diseases and episodes of depression and anxiety. This therapy uses principles of Appreciative Inquiry (AI) (Srivastava and Cooperrider ,1990; Cooperrider and Srivastva 1987) in inculcating positive belief systems and helping the client develop learned optimism (Carr, 2004). *Appreciative inquiry is "a* co evolutionary search for the best in people, their organizations, and the relevant world around them. It is a technique which empowers people and organizations, mobilizes them towards action and energizes with future focus (Cooperrider et.al.2003; Shrivastava and Cooperrider, 1990). AI evolved as an Organizational Development tool and has been described as the most important advance in action research in the past decade (Bushe, 1991); as powerful second generation OD practice (French and Bell, 1995; Mirvis, 1993); as offspring and "heir" to Maslow's vision of a positive social science (Chin, 1998; Curran, 1991); as a model of a much needed participatory science, a "new yoga of inquiry" (Harman, 1990) where the term yoga comes from the Sanskrit root yug which means link or bond. AI helps make the memory link by concentrating systematic inquiry onto all aspects of the appreciable world. It is a methodology that takes the idea of the social construction of reality to its positive extreme (Gergen, 1990).

Appreciative Inquiry is a particular way of asking questions and envisioning the future that fosters positive relationships and builds on the basic goodness in a person, a situation or an organization. According to Cooperrider and Whitney (2005) AI involves, in a central way, the Socratic strategy and practice of asking the right questions that strengthen a system's capacity to comprehend, anticipate and heighten positive potential.

AI basically has two words: appreciate and inquire. Appreciation refers to recognition of the best in people and the world around them. The other important word is inquiry which refers to exploration and discovery of what works by asking well crafted relevant questions.

In this therapy techniques of visualization, relaxation and inducing a state of trance are combined with the art of appreciative inquiry. The therapy works by focusing the attention of an individual on its most tangible and intangible strengths, capabilities, resources, positive potentials and assets. PAT is based on the notion that human system grows and changes in the direction of what it focuses upon, i.e., the positive goal you wish to achieve. Perception of those things which give

life, health, vitality and excellence to living human systems, affirmation of past and present strengths, successes, assets, high points and potentials are valued in this process.

### *PAT: Operational Definition*

Participative Appreciative Therapy (PAT) is basically a life focused approach including the process of transformation initiated through catharsis and rapport building in a motivational environment. Connecting to the subconscious of the client it focuses on life giving factors, visioning the possibilities and opportunities based on positive past experiences , making positive action plans and commitments with an emotional glue, taking actions, appreciating and celebrating for positive outcomes .

### *PAT Beliefs*

Participative Appreciative Therapy is thus founded on the following set of beliefs about human nature and human behavior:

1. People individually and collectively have unique gifts, skills and contributions to bring to life. When given an enabling environment, these skills and unique gifts can be used for attaining desirable outcomes.
2. Human social systems are sources of unlimited relational capacity, created and lived in language. People are curious and they like to tell stories and listen to stories. They pass on lot of information related to their value system and belief patterns which is extremely helpful in understanding their issues, behavior and problems. People delight in doing well in the eyes of those they care about and respect. People create identities and knowledge in relation to one another.
3. The images we hold of the future are individually created and, once articulated, serve to guide the individual. Individual's vision of the future has a very deep and profound influence on the way s/he acts in the present. Individuals grow into the images they create. Hence if we are out to achieve deep or profound change we need to spend some time crafting or creating appropriate visions of the future. The vision of future, when creates its place in the subconscious and unconscious mind of the person, it becomes a powerful guiding force.

### *PAT Principles*

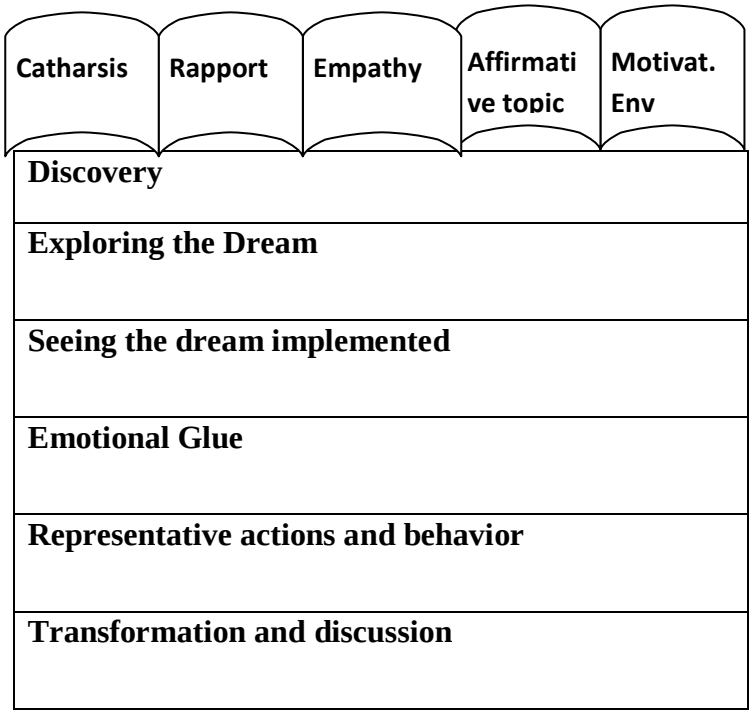
1. You find what you search for (what you focus on becomes your reality). For example Rakesh focused upon his colleagues being jealous of him and creating problems in his growth, he found several incidences which supported his hypothesis and he narrated them in the board meeting. On the other hand Rekha looked for situations where his colleagues came forward in her support and she identified many such incidences in the same organization with same set of employees. This is in reference to the environment.

2. Words are world and language creates reality, e.g. Addison said that he has learned thousand ways by which bulb could not be created. If he had called his attempts as failures he could have never made thousand attempts.
3. You get what you expect e.g., Studies on placebo effect have shown that if you believe that the medicine you are taking will help you, you will recover even if the tablet had no medicinal value.
4. When you enjoy doing something the results are achieved faster, for e.g. morning walk with a good friend is much longer than otherwise.
5. Thoughts and actions based on life factors will result in productive outcomes. e.g., Raj did not improve in studies till criticized for not paying attention to studies, not being serious and wasting time with friends. Same Raj improved drastically when appreciated in the class for giving a very good presentation and started studying seriously.

***Process of PAT***

Espousing the principles and beliefs mentioned above the most significant element of PAT is identification of a positive therapeutic goal. The therapeutic goal has to be worded positively i.e. what is to be achieved and not what is to be discarded. It is this goal on which the client and the therapist would work together. An agreement between the client and the therapist on the goal and active participation by the client in the therapeutic processes is a prerequisite in this therapy and therefore it is called **Participative.**

PAT is basically a two phase therapy. Phase I consists of Cream and Phase II consists of Dessert. It can also be called **Cream and Dessert** Therapy.



***Phase I: CREAM –It consists of following five components. There may not be a specific order in these five components.***

1. Catharsis
2. Rapport Building
3. Empathy
4. Affirmative Topic and
5. Motivational Environment

Catharsis will help the client to ventilate and by showing empathy during this period the counselor will be able to establish a good rapport with the client. The next most important step of the therapy is choosing an **Affirmative Topic.** Usually in a therapeutic situation the question normally asked is, "what is the problem?", "How can I help you?" In PAT the therapist would ask "Where do you want to go?" "What is it that you wish to achieve?" Since client comes with a problem focus hence even on asking the above questions the reply is often in terms of problems. The therapist would continue to ask questions till the client comes out with an affirmative issue. However it is advisable to allow the client for catharsis before reaching the affirmative topic and objective to work with and define the therapeutic goal in a positive language. E.g., in traditional therapy the problem that the client may come to 'my child speaks lie and manipulates the parents', 'I wash my hands repeatedly and cannot stop taking bath at least 10 times a day'. The implication is that these problems should vanish or finish. There is no frame here about what to do instead e.g., the problem of taking bath does not mean that there will be no bathing. There has to be an alternative behaviour to replace the one which is seen as a problem. Hence the affirmative topic is about the behavior that has to replace or that one wants to achieve. It is not about finishing the problem. Hence these problems have to be reframed in affirmative language e.g., 'I want my child to speak truth and be transparent and expressive about his relationships with parents', and 'I want to take bath at the most one or two times a day and wash my hands only after taking meals or when I do something which makes my hand dirty'. Sometimes the goal is not only positively worded but the expected goal is of a much higher value and nature e.g., 'I want my child to be the best in the world with honesty and dedication in personality'. Exploring such goals have very interesting visions and expected behavior from the child which the therapist and clients work together to achieve with reality check. Once the affirmative issue is selected a motivational environment has to be maintained throughout the session where the counselor takes a commitment from the client for full active participation to reach where they wish to reach, the ultimate goal. Motivational Environment is achieved by active listening, paying attention to the concerns of the client and an assurance for attaining the future vision.

***Phase II: DESSERT***

This phase formulates the main therapy though the therapeutic effects are visible in the CREAM phase itself. It is composed of six stages:-

1. Discovery

2. Exploring the Dream,
3. Seeing the Dream Implemented
4. Emotional Glue
5. Representative Actions and Behaviour.
6. Transformation and Discussion

**i) Discovery:** The Discovery phase is a diligent and extensive search to understand and identify the "best of what is" and "what has been" in relation to the affirmative topic or ultimate goal. It begins with developing interview guide which includes well crafted appreciative interview questions. The questions are written to generate stories, to enrich the images and inner dialogue within the client, and to bring to the surface the eternal soul and the factors that gave life to his/her existence especially in reference to the affirmative topic. Since human systems move in the direction of what it focuses upon so choice of what to focus upon is both critical and strategic. The selected issue provides a framework for collecting stories, discovering and sharing the most tangible and positive experience, and creating an environment where the client participates actively with the therapist to achieve desired results. The process of positive change in the direction of affirmative topic is initiated in the very first stage of the actual therapy as it starts giving a positive outlook for one's existence and sets in motion the process of searching for desirable and positive experiences of life. Hence the discovery phase has therapeutic value.

**ii) Exploring the Dream:** The Dream phase is an energizing exploration of "what might be". The client explores for his/her hopes, engaging oneself in and out of the box thinking and dreaming the desired world of one's self, significant others and relationships at home or may be at work. This phase involves generation of creative, affirmative and hopeful images, innovative strategic vision and an elevated sense of purpose. During this state the therapist helps the client in creating the experience that the client wishes to achieve ultimately. Discovery of the best sets the mood for dreaming. In this stage the client is also challenged if the dream is very unrealistic, selfish and where space for other persons is missing. The client is guided to a realistic, attainable and responsible dream. It is more helpful to take the client in a state of deep relaxation or trance to dream. The client is motivated to have as clear perception of the desired state as if all is before her/his eyes.

**iii) Seeing The Dream Implemented**: This stage requires the client to be in a state of deep relaxation and visualizing or imagining the dream coming true. Some clients go through a lot of turmoil in this stage as it requires to create a bridge between the actual and the dream. Since the state in which the client comes is stressful and for which the client does not see a solution s/he often finds it difficult to visualize implementation of the dream. Sometimes they start the visualization and then stop in between. In such cases it may need more than one session for few clients to come to this stage depending on the severity and length of the period of the problem. With gradual effort it becomes possible. The role and behavior of client has to be, especially, elaborated in this stage. It basically involves selection and

adoption of healthy behaviors which will help the client to reach the desired state of living. It is actually living the experience that the client wishes to achieve. In this stage the client gets insights about the strategies that will facilitate her/him to reach the desired state. The task of the therapist is to explore the details of the context in which the dream is implemented. Before taking the client in the visualization stage the therapist would ask the client to give details about the environmental factors of her/his liking e.g., the physical environment (outside or inside the house, the location of mountain, snow, sea shore or riverside), colour scheme (red, pink, blue green etc.) the temperature and the climate (sunny or cloudy, hot or cold etc.), the sounds (music of choice etc.), the décor and the interior (the upholstery, paintings, show pieces etc.).

This knowledge is then used during visualization as the context in which the dream is implemented. The therapist would then take the client to the journey of visualization after few minutes of deep relaxation through progressive muscular relaxation technique or some other technique of her/his choice. The therapist would ask the client to take steps towards fulfillment of his/her dreams. The journey is slow and steady in the environment for which the client has shown her/his liking. At the end of the journey the client is asked to focus on what the client is doing (standing, sitting, lying, talking or quiet, what if talking), the people around (who all are with her/him in this time of dream fulfillment, who is doing what, who is saying what, who is feeling and expressing and thinking what etc.).

Only the client knows what are the behaviours which would help her/him to achieve the desired goals. But for certain reasons s/he is not aware about them at conscious level or s/he is not able to adopt them. During subconscious stage things start coming as crystal clear with guided visualization process. During this stage the client is also asked to look carefully and microscopically at his own actions and behavior towards achieving the goals. This reveals the capabilities, the possibilities of behavbiour, likings and desires of the client.

**iv) Emotional Glue:** Once the therapist is aware about the details of the environment in which the dream is implemented the therapist is required to lace it with emotional glue. The amygdale remembers all that is emotionally laden. During this phase the client is also fed with energy, positive thinking, capacity and capability enhancement techniques, confidence, high self esteem, appreciation by loved ones, happiness and peace on faces of loved ones etc. Hence to make the memory of the positive experience to be remembered for repetition in future the therapist would help the client focus on positive emotions as well as exaggerate them e.g., you are feeling at the top of the world as this ( the dream) is happening. The therapist would also expand the experience physically and emotionally. The client is helped to visualize/imagine oneself as impacting and spreading the positive emotions to the loved ones (friends, spouse, children, colleagues etc.) and they are happy and cheerful seeing the client achieve one's ultimate goals. The client visualizes oneself

happy, the entire environment is happy and joyous, may be the entire house, the entire neighborhood, the entire city or the world is celebrating, the people whom s/he values are extremely happy and enjoying.

Observe the face expressions of the client and the therapist would know if the client is enjoying the state or not. Let the client enjoy the state of positive visualization filled with positive experiences and emotions till s/he is comfortable as assessed by the facial expressions. Towards the end the client is asked to hold or freeze the image of happiness in some part of the body e.g., fist. The client is then asked to come back from the visualization state to conscious state with open eyes. Before the client opens the eyes s/he is suggested to rub the palms and put the warm palms on the closed eyes. Do this 2-3 times and then open the eyes. This will acclimatize the eyes from the comfort of dream to hard reality of the world. Before saying goodbye for this session the therapist should ask the client to use symbolic holding of the image as frequently as possible. Whenever the client is in pensive mood s/he should bring back the image of happiness with closed or open eyes and also use the part of the body where that scene has been frozen e.g., close the fist and feel the frozen moment rather than the entire process of implementation of dream.

**v) Representative actions and behaviour.** At the end of the session the therapist should ask the client to pick up one of the acts/behaviour s/he was doing in the visualization stage to actually do in the real life and make a commitment. Clients are quite resistant to take actions in the direction of their commitment. The therapist has to emphasize that some action may be as small as making a call or writing an e-mail is initiated. Appreciation for any small action taken by the client in the direction of its commitment, and creating opportunities for celebration are equally important part of PAT.

**vi) Transformation and Discussion:** In this phase future is crafted by a conscious effort towards re-creation or transformation of an individual's systems, structures, strategies, processes and images in a way that they are more fully aligned with the person's positive past (Discovery) and highest potential (Dream). It involves focusing specifically on personal commitments and paths forward. It initiates a series of inspired actions which bring an array of changes in the thought process and actions of the individual in one's interpretation of the world, the relationships, the communication processes, other processes and structures that support ongoing learning and innovation. Therapeutic changes occur in all phases.

Discussion is an important process of analysis and evaluation in PAT. It is done after each session and also after the session when the therapist would like to say goodbye to the client. However it is not done in a traditional manner where one asks what was wrong and what is not to be done or repeated. The three issues of discussion are important here to ask before wrapping up: "what was the best?", "you know your dream and lets discuss the first few steps that you will take in the direction of achieving your dreams", "in the next few days (before the second appointment) lets decide about the exact things that you will be doing".

Before saying goodbye reassure the subject about his capabilities and strengths (which the therapist has gathered in the discovery and dream phase) which are extremely important in reaching the affirmative goal.

In every next session explore the impact of the previous session, the frequency of use of image of happiness, carrying out the representative action and behaviour, the commitments etc. In every session the client should be enabled to have more concrete and clear visualization of implementation of the dream. Also the therapist takes the client gradually step by step forward in dream implementation as in one session you take the client only as much forward as the client can take it. It should gradually become an effortless exercise for the client. In every repeat session the emotional glue has to be added to the visualization phase. Secondly after every visualization the client should be motivated to pick up more commitments to make and ensure that s/he carries out those commitments. Discussions, public commitments (before friends and relatives), appreciation, celebration are essential parts of therapeutic process and the therapist should remember to use them as frequently as is realistic and possible.

***Stages iii and iv are repeated but often with different objectives and in reference to the said affirmative topic decided every day. If the affirmative topic is very different from the first one then all stages of DESERT phase have to be followed.***

To conclude it can be said that the aim of all therapies is to help client adopt adaptive thought processes and actions which will help in achieving the identified objectives of the therapy. PAT has the same aim only that the outcome is faster and better as a number of steps are reduced. The traditional approach is to identify the problems and then investigate the genesis of the problem, sometimes in childhood, sometimes adulthood, sometimes at conscious level and sometimes at unconscious level. The next step is to release complexes, frustrations etc with an aim to fix the problem. The investigative process often roots you in the problem and then it requires a lot of effort and time to bring the client out of that rooting and give a new positive direction. Sometimes the pursuit of identifying the causes of the problem and unpacking the repressed material is very dangerous and threatening. Also a lot of times resolving the problem is not what is actually aimed at. For example in a cases of marital conflict the husband and wife blamed each other for being very aggressive and argumentative and claimed repeatedly that the partner should stop shouting and fighting. In traditional therapies a lot of time goes in exploring the incidents of fighting and the issues on which they argued and beat each other. Then the therapist tries to solve the issues on which they fight. In PAT when the couple was asked to reach the affirmative topic they said “my wife should understand me and develop a bond with my mother”, wife said “my husband should respect me and understand my situations”. On exploring the most memorable moments of their lives, the enjoyable stories of their lives it came out that husband enjoyed sex and wished to have it more frequently and for that he looked for greater cooperation of his wife and wanted to have another child “my wife should cooperate with me in sex and have

one more child". In fact the wife had gone through with a recent abortion without the consent of the husband. The therapist then worked on their sexual compatibility and making them plan next child birth. This stopped frequent fights between them and a better understanding and also led to an acceptance and bonding between wife and his mother.

***Why Does PAT Works?***

PAT is based on power of belief system, power of positive processes combined with power of visualization. During the CREAM phase since the client is made to recollect the positive experiences of relationships, the best events and happenings of life in relation to the affirmative topic, the mood of the client changes from pensive, depressed, helplessness to feelings of goodness, optimism and a sense of achievement. Appreciating the client in this stage for her/his achievements, relationships etc. help the counselor to connect very easily and motivate the client to talk more about the positive stories of life. It also makes the client feel that everything is not as wrong as s/he used to think. The client usually generalizes her/his negative thought process to all situations in life and comes for therapy with very low self esteem and a sense of learned helplessness. PAT has a Pygmalion effect i.e., you get what you expect. It works in every circumstance and everywhere without the threat of being judgmental and critical.

PAT helps the repressed material to be replaced without unpacking it. Another major advantage of the process is that the process itself is motivating and therapeutic in nature. The process of change starts during the interviewing phase itself. Statement of the issue as an affirmative topic is insightful. PAT is search for solutions that already exist, or have worked in the past, amplify what is working, focus on life giving forces, put emotional glue to it, exaggerate the glue of positive emotions so that life giving forces becomes a part of the emotional memory and are retained. Help the client visualize the goal being implemented and seeing with clarity its own role and impact of achieving the goal on oneself and one's social, psychological and physical environment. Traditional approach is about "what problems are you having" while PAT is about "planning and taking action on the basis of "What is working well around oneself".

PAT is based on a complex philosophy that engages the entire system in an inquiry on "what works" and "why it works well". Common themes are then discovered from the data and analyzed for "what could be and what will be". The future is envisioned from the past, a past of positive memories, a past remembered with what worked. The entire system maintains the best of the past by discovering what it is and stretching it into future possibilities. In traditional system the focus is "what was not working" in the past. The moment you talk about weaknesses and problems one feels intimidated by "what is not working" hampering the flow of thought process which may otherwise lead you to innovations and solutions.

PAT works because it relies on the belief that people are capable of thinking, changing, creating wealth of wisdom and resources. People project their best if they feel respected, valued and

cared. They want to do well in the eyes of those who they care and respect. People create their identities and knowledge in relation to the therapist. They are curious and love to tell stories and listen to stories. They express their values, beliefs and wisdom in stories. Hence PAT enables clients to think and understand what is doable, help them to narrow down their area of focus and clarify for themselves the goals they wish to achieve and they can achieve, develop beliefs of self worth and a perception of possibilities and opportunities before them. All this helps them to evolve into more confident persons with higher self esteem which itself is therapeutic and helps the client to find solutions. Sometimes, rather often, they need not find solutions for problems rather focus on goals ahead which may or may not relate to the problems with which they came with. The client focuses and makes efforts to achieving what s/he wishes to achieve. The moment the client gets success in the areas in which s/he makes effort and succeeds, it gives a sense of pleasure, a sense of self worth and a lot of problems with which s/he had come initially are either no more significant, or resolved automatically.

An adolescent comes with a problem of not being able to concentrate on the study of physics. When asked to identify the goal it is “getting famous and doing well in the life” when asked to visualize the client visualizes oneself entertaining audience by playing violin and adding a sense of humor to it by funny mannerisms and few jokes in between. In the process of therapy the client clearly sees what s/he wants to ultimately achieve, make commitments and starts carrying out commitments, starts learning violin, starts playing it in college shows etc. Gradually the client is able to study physics as well to the extent that s/he manages to get decent marks. PAT generates positive thought process and the ultimate result is inspiring, constructive and motivating.

A lot more work needs to be done on this therapy. This therapy has been found very useful with people under stress, conflict and confusion about future, drug addicts, marital relationship problems, communication issues with children etc.

PAT is not just a therapy but should actually be adopted as a lifestyle. Teachers, parents and spouses should be trained to use AI and PAT in their daily life communication to understand what people are worthy of, what are the unique life giving forces for them, how to motivate them and give them joy and happiness as well. It strengthens a system’s capacity to appraise, anticipate, and enhance positive potential.

***Acknowledgments***

I express my gratitude to my faculty Dr. Anupama Shrivastava to motivate me to write about what I discuss and the way I conduct my counseling sessions. She, infact, challenged me to write than just discussing it passionately. I am very grateful to my faculty Dr. Manini Shrivastava who helped me to give new ideas and terms while writing the paper and also in compiling it. I am grateful to Nirvan Psychiatric Hospital who gave me the opportunity to use this therapy. I am

thankful to all the patients for participating in the therapy and encouraging me with positive outcomes because of which I am able to write this paper and introduce a therapy to the world of Positive Psychology.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Abramson, L. Y., Seligman, M. E. P., & Teasdale. J. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology*, 87, 49-74 .

Agrawal, M., & Dalal, A.K.( 1993). Beliefs about the world and recovery from myocardial infarction. *Journal of Social Psychology*, Jun,133(3), 385-94.Agrawal, M., Dalal, A.K., Agrawal, D.K., & Agrawal, R.K. (1995). Positive Live orientation and recovery from Myocardial infection. Social Science medicine, vol 40, No.1pp .125-130.

Burish, T.G., & Bradley, L.A. (1983). *Coping with chronic disease: Research and Application*, Academic Press. New York.

Bushe, G. R., & Pitman, T. (1991). Appreciative Process: A Method for Transformational Change. *Organization Development Practitioner*, 23(3), 1-4.

Carr, Alan (2004). Positive Psychology: The science of happiness and human strengths. *Psychology Press*, 2004.

Chin, A. (1998). Future Visions. *Journal of Organization and Change Management*, (Spring).

Cooperrider, D. (1990). Positive image, positive action: the affirmative basis of organizing. In S. Srivastva and D. Cooperrider (eds), *Appreciative Management and Leadership: The Power of Positive Thought and Action in Organizations*. San Francisco: Jossey-Bass.

Cooperrider, D. L. and Whitney, D. (2005). *Appreciative Inquiry: A Positive Revolution in Change*. San Francisco, CA: Berrett-Koehler Publishers.

Cooperrider, D., & Srivastva, S. (1987). Appreciative inquiry in organizational life. In W. Pasmore and R. Woodman (Eds.) *Research in Organizational Change and Development*, Vol. 1: 129-169. Greenwich, CT: JAI Press.

Cooperrider, D., Whitney, D., and Stavros, J. M. (2003). *Appreciative Inquiry Handbook. Bedford Heights*, OH: Lakeshore Publishers.

Cousins Norman (1983) *Healing Heart, Antidotes to Panic and Helplessness*. W W Norton & Co Inc.

Curran, M. (1991). *Appreciative Inquiry: A Third Wave Approach to OD*. Vision/Action, December, 12-14.

Dalal, A. K.,& Singh, A. (1992), Role of Causal and Recovery Beliefs in the Psychological Adjustment to a Chronic Disease. *Psychology and Health* 1992 Vol. 6, Chapter 4 pp. 193-203 © 1992 Harwood Academic Publishers GmbH .

Fagerström, L. (2010). Positive life orientation–an inner health resource among older people. *Scandinavian Journal of Caring Sciences*, Volume 24, Issue 2, pages 349–356, June.

French, W., & Bell, C. (1995). *Organization Improvement*. (5th ed.). Englewood Cliffs, NJ: Prentice Hall.

Gergen, K. J. (1990). Affect and Organization in Postmodern Society. In S. Srivastva, D. L., Cooperrider & Associates (Eds.), *Appreciative Management and Leadership*.

Greenberg. L. W., Jewett, L. S., Gluck, R. S., Champion. L. A. A., Leikin. S. E., Altieri. M. F., & Liprick. R. N. (1984). Giving information for a life threatening diagnosis: Parents and oncologists perceptions. *American Journal of Diabetes Care*, 138.649-653.

Harman, W.W. (1990). *Shifting Context for Executive Behavior: Signs of Change and Revaluation*. In S. Srivastva, D.L. Cooperrider, & Associates (Eds.), Appreciative Management and Leadership: The Power of Positive Thought and Action in Organizations (1st ed., pp. 37-54). San Francisco, CA:Jossey-Bass Inc.

Kamen L.P., Rodin J., and Selignamn M. E. P(1987). *Explanatory style and immune functioning*. Unpublished manuscript, University of Pennsylvania, Pa.

Miller, I. W., & Norman, W. H. (1979). Learned helplessness in humans: A review and attribution theory model. Psychological Bulletin. 86.93-118.

Mirvis, Philip H. (1993). *Building the competitive workforce: Investing in human capital for corporate success*. Wiley (N.Y.)

Peterson C., & Barreett L. C. (1987). Explanatory style and academic performance among university freshmen. *Journal of Personality & Social Psychology*, 53, 603-607.

Peterson C., Seligman M. E. P., &Vaillant G. E.(1988). Pessimistic explanatory style is a risk factor for physical illness: a thirty five year longitudinal study *J. Personality &. sac. Psychal*. 55, 23-27.

Peterson, C. (1988). Explanatory style as a risk factor for illness. *Cognitive Therapy*. Res 12, 117-130, 1988.

Pitkala, K.H., Laakkonen, M.L., Strandberg, T.E., & Tilvis, R.S. (2004). Positive life orientation as a predictor of 10-year outcome in an aged population. *J. Clin Epidemiol*. Apr;57(4):409-14.

Scheier, M.F., & Carver, C.S. (1985). Optimism, coping and health: assessment and implications of generalized outcome experiences. *Health Psychology*, 4, 219-247.

Seligman ,M. E. P., & Schulman P. (1986). Explanatory style as a predictor of productivity and quitting among life insurance agents. *Journal of personality and social psychology*. 50, 832-838.

Seligman, M.e.P. (2000). The positive perspective. The Gallup Review, 3(1), 2-7).

Seligman, M.E.P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction, *American Psycholgist*, 55, 5-14.

Srivastva, S., Cooperrider, D.L., & Associates (Eds.), (1990). *Appreciative Management and Leadership: The Power of Positive Thought and Action in Organizations* (1st ed., pp. 37-54). San Francisco, CA: Jossey-Bass Inc.

Taylor, S.E.(1983). Adjustment to threatening events; a theory of cognitive adaptation. *American Psychologist* 38, 1161-1173.

Weiner. B. (1985). "Spontaneous" causal thinking. *Psychological Bulletin*. 97. 74-84.

Winer, B. J. (1971). *Statistical Principles in Experimental Design.* Tokyo: McGraw-Hill Kogakusha Ltd.

Wong, P. T. P., & Weiner. B. (1981). When people ask "Why" questions and the heuristics of attributional research. *Journal of Personality and Social Psychology*. 40, 650-663.

**How to cite this article:** Agrawal M (2017), Participative Appreciative Therapy: A Positive Intervention Approach to Mental Health, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.113/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.114/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Efficacy of Motivational Interviewing On Improving Resilience among Students with Below Average Academic Performance: A Case Study

Riju Raj Roy[1]*

**ABSTRACT**

There have been researches going on that have focused on strength based approach like resilience to motivate the students for improving their academic performances. Failing to perform well can create school difficulties like academic work related issues, adjustment to school environment, behaviour regulation, etc which may later stimulate mental health problems. Thus it is very important to early identify these issues to promote the best possible outcome for students. Though studies are very limited in counselling and education but it appears to suggest that Motivational Interviewing (MI) may be effective in addressing student's academic motivation to perform well. Thus the objective of the study was to assess the efficacy of Motivational Interviewing on improving resilience among students with below average academic performance. A student with below average academic performance was selected for the study from Dibrugarh Bengali High School, Dibrugarh, Assam. Pre and post assessment of the resilience level was assessed by using the Adolescent Resilience Scale. In between pre and post assessment, MI was applied to the student for 10 sessions alternatively. Post assessment and follow-ups were done to check any improvement on resilience. The result of the study concluded that at present Motivational Interviewing has shown to be effective on improving resilience among students with below average academic performance.

***Keywords:*** *Resilience, Motivational Interviewing, Academic Performance*

**E**ducation is one of the key ingredients of human resource development. It is also referred as a fundamental human right as well as a catalyst for economic growth and human development (Okumu et al., 2008). Hence it positively nourishes one to deal effectively and make a significant contribution towards self and the society. It further psychologically strengthens an individual. Thus it is very important in life and every child should have and must get opportunity to achieve

[1] Clinical Psychologist, Hope Trust, Hyderabad, Telangana, India
*Responding Author

**Received: January 16, 2017; Revision Received: February 19, 2017; Accepted: February 25, 2017**

his or her academic potentials. Moreover education at secondary school level is supposed to be bedrock and the foundation towards higher knowledge in tertiary institutions. Studies conducted by Miller-Grandvaur and Yoder (2002) on secondary schools education found out that Secondary schools are an important part of the educational interventions. But, the main issues faced by secondary school education seem to be academic performance of students.

Most students in secondary school experience academic problem that manifests itself in the form of academic poor performance. It may cause difficulties like academic work related issues, adjustment to school environment, behaviour regulation, etc which may later stimulate mental health problems. Thus it is very important to early identify these issues to promote the best possible outcome for students. However, different people at different times have passed the blame of poor performance in secondary school to students because of their low retention, parental factors, association with wrong peers and low achievement motivation (Aremu & Oluwole 2001).

The ongoing studies have sought to find out the factors leading to downward trend in the academic performance of secondary school students. Studies have shown that the level of family cohesion (Caplan et al, 2002 cited in Diaz, 2004), and family relationships (Buote, 2001) are capable of predicting academic performance. Even the interest of students in studies have been associated with volume of work completion, task orientation of the students and skill acquisition, personality and self-concept (Moore, 1973), feeling of inadequacy (Callaham, 1971), motivation and self-confidence (Aiken, 1976), anxiety (Aiken, 1970). Moreover, individual characteristics such as intelligence, cognitive styles, and personality play an important role in learning and instruction as does the context of learning. Among all the personal and psychological variables that have attracted researchers to study educational achievement, motivation seems to be more significant in relation to other variables (Tella, 2003). Moreover research has found the role of motivation to be central to educational resilience (Ruiz, 2002).

Researchers have also pointed resilience as a crucial component in boosting academics. Resilience has been conceptualized as an individual characteristic (Werner, 2000) and the term resiliency has been used to refer good, stable, and consistent adaption under challenging conditions (Masten, 1994). Academic resilience took more attention between different components. Academic resilience includes components such as confidence, a sense of well-being, motivation, an ability to set goals, relationships/connections, and stress management. It has been also linked with school and life outcomes including academic success for students who are faced with great adversity.

A handful of literature revealed strong evidence of resilience being connected to academic success. Scales et al. (2003) found that higher levels of resiliency traits were strongly correlated

with higher grade point averages (GPAs) among middle and high school students. Similarly, Waxman and Huang (1997) reported that students with high rank on standardized tests were highly resilient, reported significantly higher levels of task orientation and satisfaction, social self-concept, achievement motivation, and academic self-concept than their counterparts who were low rankers.

Even studies have shown that resilient students sustain high levels of achievement motivation and performance despite the presence of stressful events and conditions that place them at risk of doing poor at school and dropping out of school (Alva, 1991). Thus learning skills of resilience or resilience development can benefit students to improve their performance in academics as these skills can have a lasting impact on academic performance.

Hence there have been studies going on that have focused on strength based approach like resilience to motivate the students for improving their academic performances. Though studies are very limited in counseling and education but it appears to suggest Motivational Interviewing (MI) as a client centre approach that may be effective in addressing student's academic motivation to perform well.

Motivational Interviewing, or MI, is goal oriented approach first introduced in the early 1980s by clinical professionals to help in the treating behavioural problems, such as alcoholism (Miller & Rose, 2009; Miller, 2004). This technique has been found to be effective in facilitating behavioural changes in patients. Students who learn MI also can apply it to their own behaviours, resulting in better academic outcomes (Sheldon, 2010; Pintrich, 1990). Studies have reported that MI has produced significant positive changes in academic performance and self-reported positive academic behaviour (Bala & Johansson, 2015).

Additionally, research on promoting academic achievement has found that the one single session of MI can have a beneficial effect on academic behaviours (Fuller & Taylor, 2009).

However most of the studies done were an effort to show the relationship between MI and academic performances and have put more focus on different components like confidence level or self efficacy which influences resilience rather directly to studying resilience. Hence keeping this in concern this present study is an attempt to explore the efficacy of MI on improving resilience to influence academic performance.

## METHODOLOGY

***Objective***

1. To explore the efficacy of Motivational Interviewing on improving resilience among students with below average academic performance.

***Hypothesis***

1. There will be a significant difference in the level of resilience before and after Motivational Interviewing.

***Sample***

The sample consisted single participant with below average academic performance. The sample was drawn using purposive sampling. Participant had to be within the age range of 10-15 years. Additionally, participant afflicted by behavioural problems was excluded.

***Tools used***

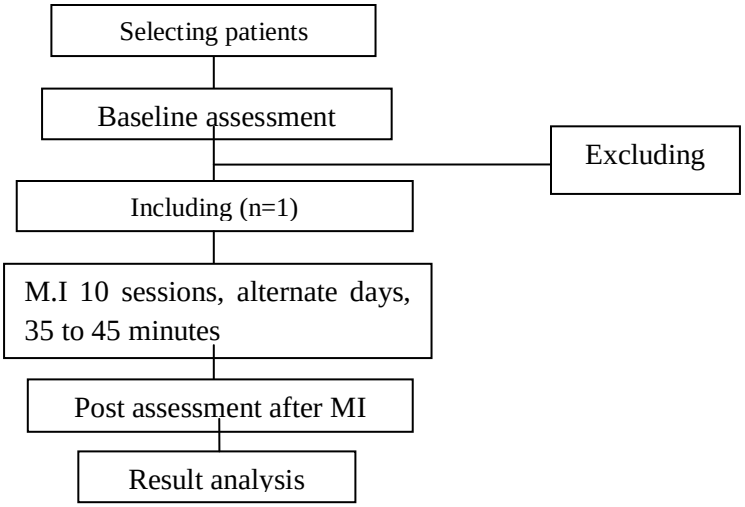
1. Socio demographic data sheet
2. Adolescent Resilience Scale- ARS (Oshio, Kaneko, Nagamine and Nakaya, 2002)

The scale has 21 items in three subscales of novelty seeking, emotional regulation, and positive future orientation. Participants rated items using a score of 5 which means definitely yes and 1 which means definitely no. The Cronbach coefficients alpha was .75 for the Novelty Seeking, .73 for the Emotional Regulation, and .80 for the Positive Future Orientation. The overall consistency was .80, confirming the internal consistency of the whole scale.

Procedure

A participant with below average academic performance was selected for the study from Dibrugarh Bengali High School, Dibrugarh, Assam. Initially participant and his parents were informed about the study and the purpose of the study. Their consent was taken in the consent form. After that demographic information was collected and following that Pre assessment of the resilience level was assessed by using the Adolescent Resilience Scale. After that MI was conducted with the participant for 10 sessions alternatively. Later Post assessment and follow-up was done twice to check any improvement on resilience using the same scale.

Design:



***Individual Session plan***

| Sessions | Activities/plans |
|---|---|
| 1 | Formal interaction and rapport formation with the participant and family members. |
| 2 | Assessing participant and family member's awareness and concern about his academic performance. |
| 3 | Baseline assessment. |
| 4 and 5 | MI focused on cognitive dissonance regarding the problem based on participant's perception about his academic performance and resilience. |
| 6 and 7 | MI focused on motivating resilience within the participant based on open ended questions and reflection on self. |
| 8 and 9 | MI focused on dealing with the ambivalence regarding the academic performance by summarizing the previous sessions. |
| 10 | Reassessment and discussion was done on the basis of post ARS. |

***Case illustration***

*Demographic details*

Index participant was 14 years old, male, studying at 7$^{th}$ grade from Dibrugarh, Assam. His father was a daily labor staying at a distant place and mother was a part time cook. He was the second child of his family. Based on his mother and school teacher's report and class test results, it was found that his academic performance was below average. He was not doing well in his exams since a long time. He was also warned of discontinuing his academics from the school by the principal if his performance does not get better. However no misconduct was reported. He was mentioned as regular, obedient in school keeping aside is academics. He was actively participating in sports. At home, he was reported as a responsible and caring son but with his studies he is not at all concerned. Whenever he was asked about his studies he would say that "ami kichu bhuji naa" and " ami mone hoy pora shone korte parbo na". The school teachers reported that from grade 1 to 7, he has never cleared his all papers and was promoted each time under consideration. His mother took him to several astrologers and faith healers but no improvement was seen. A few months back he was referred for psychological evaluation by the school principle and was brought here. Currently he has completed 10 sessions of Motivational Interviewing and has attended his 2$^{nd}$ follow up.

***Assessment***

As per the objective of the study, psychological assessment was done using:

1. ***Adolescent Resilience Scale***

This test was used for both pre and post test assessment to check the level of resilience of the participant. On pre test, in this scale, the participant had a score of 57 indicating below average resilience level. On post test the score was 73 and 77 for 1$^{st}$ and 2$^{nd}$ follow-up respectively indicating above average level of resilience.

***Intervention***

*Initial phase*

This phase consisted three sessions in which the first session included formal interaction and rapport building with the participant and his parents. In the second session the parents were asked to report their awareness and concern towards participant's academic performance at present. In the third session the aim of the study was elaborately explained and confidentiality was assured to be maintained. The participant was briefly explained about MI and its procedure along with its benefits. Following that consent was taken and the Adolescent Resilience scale was administered.

*Middle phase*

The middle phase consisted of six sessions in which the first two sessions focused on cognitive dissonance regarding the problem based on participant's perception about his will to study and academic problem. In the second two sessions he was asked to summarize what he has understood from the last two sessions. Later he was asked few questions about how he exactly feels when he is not getting enough marks to pass his papers. The remaining two sessions focused on dealing with the ambivalence regarding the problem by summarizing the previous sessions. In these sessions whatever was explained to him was again discussed but the discussion was more from his point of view. In between he was rephrased anywhere he was having any doubt about anything he didn't understand. The session was later disbanded congratulating him for his active participation for MI.

*Terminal phase*

This phase took place a week after completion of MI sessions. In this the participant was asked about his present condition and how he is dealing with his problem at present. He was also asked to briefly to rephrase what was discussed in the previous session. Later on similar follow ups were conducted twice along with administering the Adolescent Resilience Scale to assess his resilience level. The result was later discussed with him and his parents.

## RESULT

On the basis of Motivational Interviewing, participant's report about his present condition and ARS post assessment scores which came to be 73 and 77 indicating above average resilience level, it can be suggested that Motivational Interviewing has been effective for this participant and at present he is resilient enough to make his academic performance better. There was a consistency of scores maintained by the participant in emotional regulation subscale (a score of 29 for both pre and post assessment). However there was a gradual increased score in novelty seeking and positive future orientation subscales in post assessment. For Novelty seeking subscale the participant had a score of 11 in pre assessment and 27 for both the post assessments.

For positive future orientation, the participant had a score of 17 in pre assessment, 17 in 1st post assessment and 21 in 2nd post assessment.

## DISCUSSION

The present study was carried out to assess the efficacy of Motivational Interviewing on improving resilience among students with below average academic performance. It was an attempt to explore if resilience score improves after MI was given which was assessed based on the scores obtain by the participant in the Adolescent Resilience Scale in the post assessment phase.

Following the assumption it was found that there was a gradual improvement in resilience score after Motivational Interviewing was given as mentioned in the result. It was also found that there was a gradual increase in scores for novelty seeking and positive future orientation subscales in pre and post assessment. However the participant had consistent score for emotional regulation subscale in both pre and post assessments.

Though there is a dearth of literature showing Motivational Interviewing as effective on improving resilience but there are studies that have shown MI to be effective on improving self efficacy which is a significant aspect of resilience. It was found that self-efficacy and self-concept of students had a significant increase after Motivational Interviewing was given (Ashouri, Zolghadri, Nehmati, Alizadeh & Ali Issazadegan, 2015). Another study reviewing 28 published articles have found that Motivational Interviewing is able to improve the development of skills and self-efficacy (Madson, Loignon, Lane, 2009). It can be further mentioned that Motivational Interviewing helps students to segregate their goals and strengthen its own values which can help in the process of changing their behavior and lead them to become successful students and contribute to the society (Butler, 2009). Further another study done by Stait etal. (2012) provided some preliminary support for the efficacy of MI for improving the academic performance of young adolescents. And it has been identified as a fundamental unit of change, perhaps one of the most efficient approaches to change (Embry & Biglan, 2008).

## CONCLUSION AND IMPLICATION

Thus based on the purpose and the result of the present study, it can be concluded that at present Motivational Interviewing has shown to be effective on improving resilience among students with below average academic performance.

In most of the literature Motivational Interviewing has been found to be effective in improving or modifying different aspect of self for better academic performance. Thus the present study can be useful in constructing an intervention package that will include Motivational Interviewing and its essential principles and features to solve the issue of lack of resilience among students with

poor academic performance. Moreover it can also benefit the family members and teachers of the students in motivating them for reducing their stress and better dealing with their academics.

***Limitations***

1. The study is limited to only one participant. Thus the result cannot be taken for generalization.
2. The approach to the study was case study in nature. Thus there is a possibility of subjectivity.
3. The level of resilience was assessed by a single assessment tool.
4. Only two follow-ups were considered for post assessment of resilience level after intervention.

***Future direction***

1. The study may include a larger sample for better comparison.
2. The study may include multiple tools for assessing level of resilience.
3. The study may include multiple follow ups for better assessing the consistency in level of resilience.

***Acknowledgments***

The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Aiken, L. A. Jr. (1970). Attitudes towards Mathematics. *Review of Educational Research, 40,* 551-591.

Aiken, L. A. Jr. (1976). Update on attitudes and other affective variables in learning Mathematics. *Review of Educational Research, 61*, 880-815.

Alva, S. A. (1991). Academic invulnerability among Mexican- American students: The importance of protective resources and appraisals. *Hispanic Journal of Behavioral Sciences, 13(1)*, 18-34.

Aremu, A. O., & Oluwole, D. A. (2001).Gender and birth order as predictors of normal pupil's anxiety pattern in examination. *Ibadan Journal of Educational Studies, 1(1)*, 1-7

Ashouri, M., Zolghadri, P., Nehmati, M., Alizadeh, S., & Issazadegan, A. (2015). The Effectiveness of Motivational Interview on Enhancing Self-efficacy and Improving Self-concept in Underdeveloped Students. *American Journal of Educational Research, 3*(7), 923-928.

Bala, S., & Johansson, V. (2012). *The effect of motivational interviewing training on student's counseling skills and confidence: A systematic literature review.* Master's Thesis in Odontology with Specialization in Oral Health, Malmo University.

Boute, C. A. (2001). *Relation of autonomy and relatedness to school functioning and psychological adjustment*. Dissertation abstract international section A: humanities and social sciences, *62(1)*.

Butler, S. H. (2009). *Motivational interviewing: a school counselors guide*. M.S dissertation, Winona State University.

Callaham, W. L. (1971). Adolescent Attitude towards Mathematics. *Mathematics Teachers*, *64*, 751-753.

Caplan, S. (2012). Sociemotional factor contributing to adjustment among early entrance college students. *Gifted Children Quarterly, 46(2)*,124-134.

Diaz, A. L. (2004). Personal, family, and academic factors affecting low achievement in secondary school. *Electronic Journal of Research in Educational Psychology and Psychopedagogy, 1(1)*, 43 – 66.

Embry, D., & Biglan, A. (2008). Evidence-based kernels: fundamental units of behavioral influence. *Clinical Child and Family Psychology Review, 11(3)*, 75–113.

Fuller, C., & Taylor, P. (2009). A Toolkit of Motivational Skills. West Sussex, England.

Madson, M. B., Loignon, A.C., & Lane, C. (2009). Training in motivational interviewing: a systematic review. *Journal of substance abuse treatment, 36*, 101-109.

Masten, A. S. (1994). Resilience in individual development: Successful adaptation despite risk and adversity.

Miller, W. (2004). Motivational Interviewing: Facilitating Change across Boundaries. *Mayo Clinic Proceedings, 79(3),* 327-331.

Miller, W. R., & Rose, G. (2009). Toward a Theory of Motivational Interviewing. *The American Psychologist, 64(6)*, 527-537.

Miller-Grandvau, Y., & Yoder, K. (2002). *A literature review of community schools in Africa*. Support for Analysis and Research in African (SARA) Project, Academy for Educational Development.

Moore, B. D. (1973). *The Relationship of 5th grade students Self Concept and attitude towards mathematics to academic achievement in arithmetic computations, concept and application*. Dissertation Abstract International, *32*, 4426 A.

Okumu, I. M., Nakajjo, A., & Isoke, D. (2008). Socio-Economic Determinants of Primary School Dropout: The Logistic Model Analysis.

Oshio, A., Kaneko, H., Nagamine, S., & Nakaya, M. (2003). Construct validity of the adolescent resilience scale. *Psychological Reports*, *93*(3f), 1217-1222.

Oshio, A., Nakaya, M., Kaneko, H., & Nagamine, S. (2002). Development and validation of an adolescent resilience scale. *Japanese Journal of Counselling Science*, *35*(1), 57-65.

Pintrich, P. R., de Groot, E. V. (1990). Motivational and self-regulated learning components of classroom academic performance. *Journal of Educational Psychology, 82(1),* 33-40.

Ruiz, Y. (2002). *Predictors of Academic Resiliency for Latino Middle School Students*. Dissertation, Boston: Boston college.

Scales, P. C., Roehlkepartain, E. C., Neal, M., Kielsmeier, J. C., & Benson, P. L. (2006). The role of developmental assets in predicting academic achievement: A longitudinal study. *Journal of Adolescence, 29(5),* 692-708

Sheldon, L. (2010). Using Motivational Interviewing to Help your Students. *The NEA Higher Education Journal*, 153-159

Strait, G. G., Smith, B. H., McQuillin, S., Terry, J., Swan, S., & Malone, P. S. (2012). A Randomized Trial of Motivational Interviewing to Improve Middle School Students'academic Performance. *Journal of Community Psychology*, *40*(8), 1032-1039.

Tella, A. (2003). *Motivation and Academic Achievement in Mathematics.*

Waxman, H. C., & Huang, S. L. (1997). Classroom instruction and learning environment differences between effective and ineffective urban elementary schools for African American students. *Urban Education, 32(1*), 7-44.

Werner, E. E. (2000). *Protective factors and individual resilience*. Cambridge: Cambridge University Press, 115-132.

**How to cite this article:** Roy R (2017), Efficacy of Motivational Interviewing On Improving Resilience among Students with Below Average Academic Performance: A Case Study, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.114/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.115/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# A Study of Psychosocial Profile of Mentally Handicapped Children and Psychopathology in their Parents

Dr. Anup Rathi[1]*, Dr. Mayur Muthe[2], Dr. Anita Nagargoje[3]

**ABSTRACT**

***Aim:*** To study the socio-demographic profile of mentally handicapped children and to compare the Psychiatric morbidity in parents of mentally handicapped children with that of parents of non handicapped children. ***Materials and Methods:*** The sample under study consisted of 50 children of both sexes 30 of these were mentally handicapped children & 20 children were non handicapped. IQ was assessed using Coloured Progressive matrices and Goddard form board. SCID I was used to assess Psychopathology of parents. ***Results:***The prevalence of consanguinity, pregnancy complications, co-morbidity (speech and seizure disorder) and psychopathology in mothers was high in mentally handicapped children as compared to non handicapped children.

***Keywords:*** *Mentally Handicapped Children, Mental Retardation, Psychopathology in Parents of Mentally Handicapped*

**A**t the beginning of this century, children suffered from a wide range of threatening medical illnesses, for which there was hardly any satisfactory treatment. Today, this situation has changed gradually but dramatically. Improved sanitation, diet and housing have led to general better health and resistance to diseases. Widespread introduction of vaccination programs has led to the decrease in the incidence of various diseases like polio, T.B. Small pox, etc. Improved neonatal care has reduced the incidence of birth handicaps.

It has long been established that disable and handicapped people are seen as 'different' from normal people, often being stereotyped as dependent, isolated, depressed and emotionally unstable. In turn, these public stereotypes lead to narrower range of role expectations and more restrictions on behaviors and opportunities for disabled people. Indeed, the major handicap of

[1] Assistant Professor, Dept of Psychiatry, Dr Ulhas Patil Medical College, Jalgaon Khandesh, Maharashtra, India
[2] Assistant Professor, Dept of Psychiatry, Dr Ulhas Patil Medical College, Jalgaon Khandesh, Maharashtra, India
[3] Assistant Professor, Dept of Psychiatry, Dr Ulhas Patil Medical College, Jalgaon Khandesh, Maharashtra, India
*Responding Author

**Received: January 18, 2017; Revision Received: February 20, 2017; Accepted: February 25, 2017**

disabled people is not their specific disability so much as the attitudes of general public towards them.

Children make large demands on society in terms of money and professional shifts the emotional problems of parents are no less daunting. In these conditions, the exact course & time of deterioration may be unpredictable. Either ways parents have to cope with a treat deal of uncertainties about their child's health and future.

A common belief in this regards is that the presence of a disabled child has a negative effect on his family. This is one of the most common reasons cited to parents while recommending institutionalization for their child. This strongly indicates the negative attitude and avoidance of parents and society towards such children.

Hence, a study exploring this complex disability was taken up to understand the impact of child disability on Parents.

***Aim***

To study the socio-demographic profile of mentally handicapped children and to compare the Psychiatric morbidity in parents of mentally handicapped children with that of parents of non handicapped children.

## MATERIALS AND METHODS

The sample under study consisted of 50 children of both sexes 30 of these were mentally handicapped children & 20 children were non handicapped.

***Mentally handicapped***

30 mentally handicapped children of the same group of 8-12 years attending a special school for the mentally retarded were selected. Children with accompanying physical handicapped were excluded from the study.

***Non handicapped***

20 non handicapped children matched on socio-demographic variables were selected from the relatives accompanying patients to various OPDs in general hospital.

A Semi unstructured Performa was prepared and administered. Observations included: - Personal data, details about illness – severity of the handicap, co morbidity present, possible biological causes as mother's age at child birth, pregnancy complications, etc.

***Instruments Used***

1. Intelligence Quotient in the subjects was assessed using the Colored Progressive matrices and the Goddard Form board.
2. SCID I was used to assess the psychopathology of parents.

## RESULTS

***Sociodemographic Profile***

***Table 1: Age Distribution***

| | 8-10 yrs | 11-12 yrs | Total |
|---|---|---|---|
| Mentally Handicapped | 21 (70%) | 9 (30%) | 30 (100%) |
| Mild | 9 | 3 | 12 (40%) |
| Moderate | 12 | 5 | 14 (56.60%) |
| Severe | 0 | 1 | 1 (3.33%) |
| Non Handicapped | 13 (65%) | 7 (35%) | 20 (100%) |

On studying the age distribution of the 2 groups, 21 (70%) of mentally handicapped & 13 (60%) of non-handicapped children were in the age group 8-10 yrs. Out of these 12 (40%) had mild retardation, 17 (56.67%) had moderate & 1 (3.33%) had severe retardation.

***Table 2: Sex distribution***

| | Male | Female | Total |
|---|---|---|---|
| Mental Retardation | 17 (56.7%) | 13 (43.3%) | 30 (100%) |
| Mild | 4 | 8 | 12 |
| Moderate | 12 | 5 | 17 |
| Severe | 1 | 0 | 1 |
| Non handicapped | 10 (50%) | 10 (50%) | 20 (100%) |

Out of 30 M.R. children 17 (56.7%) of the retarded children were males & 13 (43.3%) were females. Amongst the non-handicapped 10 (50%) were males & 10 (50%) were females.

***Table 3: Type of family***

| | Joint | Nuclear | Total |
|---|---|---|---|
| Mental Retardation | 3 (10%) | 27 (90%) | 30 (100%) |
| Mild | 1 | 11 | 12 |
| Moderate | 12 | 5 | 17 |
| Severe | 1 | 0 | 1 |
| Non handicapped | 4 (20%) | 16 (80%) | 20 (100%) |

On studying the type of family 3 (10%) of mentally retarded, and 4 (20%) of non-handicapped children belonged to joint family. The rest i.e. 27 (90%) of mentally handicapped children & 16 (80%) of non-handicapped children belonged to nuclear family.

***Table 4: Consanguinity***

| | Present | Absent | Total | P-Value |
|---|---|---|---|---|
| Mental Retardation | 15 (50%) | 15 (50%) | 30 (100%) | MR Vs NH P>0.05 |
| Mild | 5 | 7 | 12 | |
| Moderate | 9 | 8 | 17 | |
| Severe | 1 | 0 | 1 | |
| Non handicapped | 6 (30%) | 14 (70%) | 20 | |

On studying the prevalence of consanguinity in these groups, 15 (50%) of mentally retarded children & 6 (30%) of control were born of consanguineous marriage.

No significant different was found in the prevalence of consanguinity amongst the 2 groups.

***Table 5: Mothers Age***

| | </= 30 | >30 | Total |
|---|---|---|---|
| Mental Retardation | 23 (66.66%) | 7 (23.33%) | 30 (100%) |
| Mild | 8 | 4 | 12 |
| Moderate | 14 | 3 | 17 |
| Severe | 1 | 0 | 1 |
| Non handicapped | 17 (85%) | 3 (15%) | 20 (100%) |

23 (66.66%) of mentally retarded and 17 (85%) of non-handicapped children were born when mothers age was less than 30 yrs. whereas 7 (23.33%) of mentally retarded & 3 (15%) of non-handicapped were born when now these age was more than 30 yrs.

***Table 6: Pregnancy complications***

| | Present | Absent | Total | P-Value |
|---|---|---|---|---|
| Mental Retardation | 15 (50%) | 15 (50%) | 30 (100%) | MR Vs Control P< 0.05 |
| Mild | 5 | 7 | | |
| Moderate | 9 | 8 | | |
| Severe | 1 | 0 | | |
| Non handicapped | 3 (15%) | 17 (85%) | 20 (100%) | |

Pregnancy complications were present in 15 (50%) of mentally retarded and only 3 (15%) of non-handicapped children.

Amongst the mentally retarded children 1 each only had prenatal or postnatal, 7 had natal, and 6 had more than 1 type of birth complications. In non-handicapped children, all 3 had natal complications.

The incidence of pregnancy complication was significantly more in mentally retarded as compared to non-handicapped.

***Table 7: Co morbidity (Speech defect, Seizure disorder)***

| | Present | Absent | Total |
|---|---|---|---|
| Mental Retardation | 21 (70%) | 9 (30%) | 30 (100%) |
| Mild | 6 | 6 | 12 |
| Moderate | 14 | 3 | 17 |
| Severe | 1 | 0 | 1 |
| Non handicapped | 0 | 20 (100%) | 20 (100%) |

20 (70%) of mentally retarded children while none of the non-handicapped children had medical co morbidity.

Amongst the mentally retarded children, 17 had speech defect, 1 had seizure disorder while 3 had both.

***Psychoathology in Parents***

***Table 8: Fathers Psychopathology***

| | Present | Absent | Total | P-Value |
|---|---|---|---|---|
| M.H. | 9 (32.1%) | 19 (67.9%) | 28 (100%)* | MR Vs NH >0.05 |
| N.H. | 4 (20%) | 16 (80%) | 20 (100%) | |

** 2 Fathers expired*

Fathers of mentally retarded children had higher incidence of psychopathology as compared to fathers of non handicapped children.

Amongst father of M.H. children, 3 had dysthymia, 1 had anxiety disorder & 5 had alcohol dependence. Amongst fathers of non handicapped children, 2 had alcohol dependence, 1 each had anxiety disorders and dysthymia.

On comparison of incidence of psychopathology in fathers, none of the group significantly differed.

***Table 9: Psychopathology of Mother***

| | Present | Absent | Total | P-Value |
|---|---|---|---|---|
| M.H. | 18 (60%) | 12 (40%) | 30 (100%) | MR Vs NHP <0.05 |
| N.H. | 3 (15%) | 17 (85%) | 20 (100%) | |

On comparison, psychopathology of mothers of mentally handicapped children was significantly high as compared to mothers of non handicapped children.

Amongst mothers of mentally handicapped children, 12 had dysthymia, 5 had anxiety & 1 had depression. Amongst the non handicapped group, 2 had anxiety and 1 had depression.

## CONCLUSION

Mothers of handicapped children had higher psychiatric morbidity as compared to the mothers of non handicapped children; whereas the same trend was not observed amongst fathers.

***Acknowledgments***

The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Abramowitz Helen K, Rischardson Stephen A. Epidemiology of severe mental retardation in children Community Studies. *American Journal of Mental Deficiency*. 18-39

Blacher Jan, Meyers C E A review of attachment formation and disorder of handicapped children, *American Journal of Mental Deficiency*, 1989, 87 (4), 359-371.

Bonham Sharon Prince, Addison Susan: Families and mentally retarded children: Emphasis on father. *The Family Coordinator*, 1978 July, 221 – 230

Bradshaw Jonathan, Lawton Dorothy : Tracing the causes of stress in families with handicapped children British, *Journal of Social Work*, 1978 8(2), 181-192-

Byrne E.A. Cunningham C. C. The effects of Mentally Retarded children on families – A conceptual Review, *Journal of Clinical Psychology and Psychiatry*, 26 (6), 847 – 864, 1985

Channabasavanna S.M. Focus on the Mentally Underprivileged. *Indian Journal of Psychiatry*. 1985 April, 27 (2), 109 – 110

Chatuvedi Santosh K. Malhotra Savita: Parental attitudes towards mental retardation. *Child Psychiatry Quarterly*, 96 – 101

Crnic Keith A. et al : Adaptation of families with mentally retarded children: A model of stress, coping and family ecology. *Indian Journal of Mental Deficiency*, 1983, 88(2), 125 – 138.

Cummings S. T. The impact of child's deficiency on the father. *American Journal of Orthopsychiatry*, 1976 April, 46(2), 246 – 255

Fowle Carolyn M : The effect of the severely Mentally Retarded child on his family.

Friedrich William N. Et al. : Psychosocial Assets of parents of handicapped and non handicapped children. *American Journal of Mental Deficiency*, 1981, 85(5), 551 -553.

Girimaji R. Satish Chandra : Family intervention in mental retardation – An overview. *NIMHANS Journal*, 1993 January, 11(1), 21 – 26.

Jehan Kaisar et al.: Impact of parental education in the adjustment progress of their mentally retarded children, *Child Psychiatry Quarterly*, 153 – 156.

Mishra L.S.et al : Psychoclinical symptoms and factors associated with natal history of mentally retarded children. *Clinical Psychiatry Quarterly*, 162-167

Nanda Shukla: Some probable factors causing mental retardation. *Child Psychiatry Quarterly*, 106 – 111.

Narayan HS, Rao P Madhu, Subbakrishna DK, Rao BS Sridhara Rama: Observation of mentally retarded cases with special reference to consanguinity. *NIMHANS Journal*, 1987 July, 5(2), 121-123

Pathak M.P. et al.: Some psychosocial factors associated with mental retardation. *Child Psychiatry Quarterly*, 116 – 122.

Prabhu GG: Special problems of the mentally retarded. *Indian Journal Of Mental Retardation*, 1968, 1(2), 87-94.

Wikler Lynn et al.: Chronic sorrow revisited: Parent Vs. Professional depiction of the adjustment of parents of mentally retarded children. *American Journal of Orthopsychiatry*, 1981 January, 51(1), 63 – 70.

**How to cite this article:** Rathi A, Muthe M, Nagargoje (2017), A Study of Psychosocial Profile of Mentally Handicapped Children and Psychopathology in their Parents, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.115/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.116/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# 'I have Depression and others have Anxiety': Cognitive Representation of Depression

Vishal M.V.[1]*

**ABSTRACT**

Depression is the most common neurotic illness which affects roughly more than 350 million people all over the world and the prevalence of depression is more common among women than in men (WHO 2016). However, the awareness level of depressive disorders is low among the general public. Therefore persons with depression are generally not getting proper care and support from the family as well as the society. This study illuminates the challenges faced by a lady who had suffered from depression more than three decades episodically. This study follows the single instrument case study (Stake, 1995) research structure, describing the details incorporating the edited quotes from informants. After the description of the case, researcher focus on the key issues (themes) to understand the complexity of the case. The themes were described in detail as the lesson learned (Guba & Lincoln, 1981) from the case. The study reveals the strategies adopted by the study participant to overcome depression and its impact.

***Keywords:*** *Depression, Neglect, Social Network, Rehabilitation and Self-reliant*

The current demographic and epidemiological transition imply depression will account 5.7 percent of the total burden of disease and it would be the second leading cause of disability-adjusted life years (DALYs) second only to heart disease by 2020 (Lopez et al., 2006). Depression has social, psychological and biological factors. Most commonly depression is caused by the adverse life events (WHO, 2016). The cause of depression is hypothesised as the dopamine irregularities in the brain. However, the social factors cannot be neglected out. The depression is characterized by, lack of interest, feeling of loneliness and worthless. The depression affected persons show a tendency to live away from the society. This peculiar feature is the main source of identification of depression in the early stage. Since depression is silent as well as crude; none can easily understand the intensity of the illness. Therefore the onset of depression becomes unnoticed. The lack of awareness of the society towards the neurotic mental illness is catalyzing this phenomenon. Therefore mental illness especially neurotic illness do not

[1] Ph.D Scholar , Dept. of Social Work, Pondicherry University, Puducherry, India
*Responding Author

**Received: February 6, 2017; Revision Received: February 21, 2017; Accepted: February 28, 2017**

get proper treatment from the primary health care service as it has no demand from the general public due to unawareness. This may even lead up to the most severe consequence of depression suicide. This case study depicts triumph of a lady who she fought all odds to resistor her illness.

## REVIEW OF LITERATURE

The prevalence of depression is more common among women than in men (WHO, 2016). It is due to the higher risk of first onset or recurrence (Kessler, Berglund, Demler, & Jin, 2003). Depression is widely prevalent in women in India across all age groups. Depression is a serious condition that can impact every area of women's life (Bohra, Srivastava, & Bhatia, Depression in women in the Indian context, 2015). The impact of depression affects the patient's social life, family relationships, career, and one's sense of self-worth and even the purpose (Bohra, Srivastava, & Bhatia, Depression in women in the Indian context, 2015). The patients with depression have significant impairment on measures of quality of life, disability, social support, and marital adjustment. This situation is positively correlated with duration of illness and severity of depression. (Subodh, Avasthi, & Chakrabarti, 2008). The relationship of stigma to both depression and somatization in psychiatric patients of south India are distressing, perceived stigma was more for depressive symptoms as well as depressive symptoms were perceived as socially disadvantageous as compared to somatization symptoms (Raguram, Weiss, Channabasavanna, & Devins, 1996). The multiple roles played by Indian women contribute to stress, thereby making her susceptible to depression, which is often under-reported due to stigma (Bohra, Srivastava, & Bhatia, Depression in women in Indian context, 2015)

## METHODOLOGY

Case study research is a qualitative approach in which the investigator explores a bounded system (a case) or multiple bounded systems (cases) over time, through detailed data collection process involving in- depth interview, and reports case description and case- based themes (Denzin & Lincoln, 2003). This study follows the single instrument case study (Stake, 1995) research structure, describing the details incorporating the edited quotes from informants. After the description of the case, researcher focuses on the key issues (themes) to understand the complexity of the case. The themes were described in detail and as the lesson learned (Guba & Lincoln 1981) from the case. The study strictly observed the ethical aspects of the research through informed consent about the research moreover the name of the study participant changed to Sukanya to keep the privacy of the study participant.

### *Summary of the case*

Fifty-one-year-old Sukanya (Name changed) first had the signs of depression at the age of eighteen. The first phase of depression went away with the help of medication. The first relapse was at the age of thirty-five, after her divorce. In the second phase, she struggled a lot to overcome the medical condition. Rejection from the family and lack of financial support were predominant after the relapse. The second time relapse occurred at the age of forty-five followed

by the death of her father. This incident put her one step back. However, it was the truing-point, where she got several other opportunities to get engaged outside the family and set her free. Now she is running her own small scale business in her hometown. Above all, she becomes a well-accepted personality in the local village with the active participation of social development and women empowerment initiatives. According to her, I am living with depression... it gave a lot of energy to fight against all hurdles, gives me energy to actively participate in social activities right now. Yes, I have depression and others still have anxiety on me.

***Data Analysis***

The recorded interview was transcribed into the regional language (Malayalam) thereafter into English for the data analysis purposes. The data analysis process ended up into six themes.

***Theme-I: Denial***

*The chance of denying the symptoms of depression is high if the patients and family are not well aware of it. It leads to the patient and the family members to avoid the existence of depression as well as seeking for an apt professional help.*

When the study participant was 18 years old, she was brought to a doctor and identified that the fatigue was due to discrepancies of vitamins or minerals. Therefore, she was prescribed with some tonic. Even after a week of treatment, she could not get relief from her headache. According to her perception she was in a fantasy of getting close to death. The second time she was taken to a psychiatric practitioner, the doctor declared that she has depression and advised her to take some medicine! But the word "depression" was disapproving for her parents and other family members. Within a week she became active and restored her real state of mind with the help of medication. Thereafter the curiosity to know more about depression followed her each step. According to her word "it was quite difficult to get enough information and I searched many sources to discover it more vividly and I fully understood about depression after the second entry of depression at the age of 35. This time I squeezed the doctors to obtain the maximum knowledge of depression!"

***Theme: II- Dormancy***

*Proper treatment and active engagement in daily life activities are very important to minimise the relapse of depression.*

Study participant and her family members believed that depression would vanish like a fever. Therefore the occasional blues never put her under any intrinsic feelings. The advice to discontinue further medication had been a relief for her. According to her 'I became an active member of the family but the onset of cancer to my mother put me on nails. It transformed me from a daughter to a home nurse. The next ten years I could not have even a thought on my depression!"

***Theme: III-Triggers***

*Triggers are the psychosocial or environmental factors which can initiate the relapse of any mental illness. Personal, familial and social factors were the main triggers identified in this case.*

The death of the mother and sudden breakage of marital relationship put her in a deep agony. The death of mother was not affected seriously to the relapse of depression but the compelled marriage and divorce invited her lot of criticism. This incident provoked her family members, relatives and some friends to withdraw their support and became the main source of pressure on her. According to her she became in a *pressure cooker!* The family member's believed that she would not come with their rule and started to avoid her presence in all occasion since they believed that the study participant was pretending to escape from her duties. These situations put me in hell, which made her alone, Yes, I have depression, and others have anxiety about my future. But my family and relatives still believe that I was pretending like a patient to get rid of from duties."

***Theme-IV- Withstanding***

*Accepting the diseases and adhering the treatment plan have paramount importance in the recovering process of depression. It gives a road map to the patient about the steps to be taken for the speedy recovery from it.*

The relapse of depression (at the age of 36) evoked the study participant to find a stress – free abode to live in. With the help of the father she brought a small home for the same. This time she became economically fragile. She did various jobs in this period, such as a home nurse, small business, office attendee, and finally, she started bakery business along with the office attendee job to survive with her father. According to her 'Anyhow I do not stop medication and consultation with the doctor. It can be cured with the help of medicine and a stress-free life. Though I have depression I made a number of friends within a short span of time. It includes petty -shop owner to bank managers for running my small business for livelihood'.

***Theme-v-Phenomenon***

*The experience of living with depression can evoke personalized phenomenon to the patient. It is greatly influenced by the patient's approaches to the illness and their social supports*

The experience of living with depression metaphorically stated by the study participants as the loss of her legs in an accident. This is exacerbated by the death of her father and the loss of social networks. It brought the condition of loneliness and extreme economic instability. According to her, no family, no friends, I was alone in my home… I could have the opportunity to do anything… but I did not! This socially withdrawn life was not agreeable to her inner mind. She took the advice of doctors to overcome this situation. The medicine again cured her physical

illness but her social life was still stagnated for long again. The voluntary help of a professional social worker helped her to make social relationships more active again. According to her words, 'Now I don't have any hostility towards my relatives because they were ignorant about my problem. I understood mental illness, especially neurotic illness and it is quite hard for the common people to understand. It is due to their ignorance about the mental illness. Nowadays I am contented to what I am doing. The agony of others towards my predicament went off now. They understood that I have the capacity to survive. Now I am engaging in all social and familial activities as a free bird. Sometimes I even forget that once I have depression and it may revisit me at any time!"

***Theme- VI-Identity***

*Identity lose is the crucial aftermath of metal- illness. Even after the complete cure of the disease the stain of mental- illness still remains.*

According to the study participants she had nothing to lose as an individual, but she had a lot to lose in terms relationships and friends. During the time of severe depression, she lost herself in the hell. She felt that her time was going to end in few days. And she was singled out from all familial affairs. Then she got courage from one of my close friend who helped her to sort out the problem of identity. Meanwhile, she got a loving elder relative she gave shelter for her for six months. Through these, she developed her confidence. She reinvented her from the depression patient depression- a survivor. She started avoiding the stress evoking situations and started searching for the stress- free situation where she can open up herself as what she is. Now she has everything even her family and relatives. And now she is the much well-accepted person in the society. She is being invited to all kinds of social programs as the key organizer. In her words- I established myself from fragile lady to strong lady. I thank all these to my villagers, doctors, relatives, and the social worker for this unimaginable recovery of myself."

## DISCUSSION

The emerged themes point out the psychosocial factors which made a significant influence on the study participant during and after the course of depression. The theme denial indicates general tendency of the respondent and the family members to deny the existence of depression due to unawareness. This attitude reduces the chance of getting proper treatment at the right time. Moreover, it has the potential to initiate conflict between the patient and their family even after the revelation of the existence of depression. It is due to the strong preoccupied mental status of the patient and the family that all mental illness has schizophrenia-like characteristics. Therefore, neurotic disorders do not get needed attention much. It leads to denying the occurrence of depression as if a common headache.

The occurrence of depressive disorders is connected with the psychosocial aspects of the patients. If the patient gets a good psychosocial environment the chance of occurrence of

depression to be minimized. The theme of dormancy indicates this phenomenon of the disease in which engaging environment reduced the chance relapse of depression the study participant. In this case, the patient got enough opportunity to engage themselves in her family affairs after the onset of depression as an important member of the family after the recovery of the onset of depression. The triggers are the critical factors which can cause the relapse. The factors such as familial denial, misunderstandings, loss of friends, the death of loved ones, loss of income compulsion, marriage, divorce and loneliness are the main triggering factor acted on the study participants. The According to the nature of the patient's strengths the influence of this trigger varies. The triggers have positive and negative impacts. The positive impacts include the motivation to overcome the influence of depression through proper medication and personal efforts. The tendency to withdraw from the social activities, loneliness, death ideation and loss of identity are some of the negative impacts of triggers.

Depressive disorders lead the patient to the situation of powerlessness. To withstand to this condition patient has to get proper treatment and psycho-social supports. Otherwise due to the overwhelming psychosocial stresses could create an existential- threat on the patients which invites the condition of identity loss. The whole course of living with depression evoke personalized phenomenon of depression on the patient. Disruption in familial and social relationships during after the course of the depressive episode constructs the magnitude of the phenomenon of being with depression. Therefore the phenomenon of depression is the resultant of the whole effort made by the patients to cope with the stressful events during the sick time and aftermath of depression. Coping strategies and its impacts validate the phenomenon as positive or negative and lead to the development of new identity after the recovery from the depression.

## CONCLUSION

This study reveals the impact of depression on women in a rural village in Kerala, India. Depression can reduce the quality of social life, family relationships, career, and sense of self-worth and purpose of life. In the case of women, the impacts of depression are high due to the gender roles acting upon the illness. Therefore the depression among women have not been reaching to the proper medical care, Indian general public as of now in India. Indian general public needs proper awareness and medical support to familiarize with the mental illness especially neurotic since it has not been recognized as the major social health issue as having the same importance as major physical illness. In order to prevent the magnitude of the depressive illness and for its effective treatment social awareness creation is crucial. Besides this, family education programs on neurotic illness also could be effective since family has very important role in treating depression and other related mental illnesses. In order to curb the morbidity of mental illness Government has to initiate comprehensive mental health prevention programs. Community mental health programs can play a critical role in this regards. For this empowering Primary Health Centers (PHC) to address the mental health issues also to be considered. Besides,

partnership with private and voluntary organisations are also a good options for the government to embark mental health promotions programs in rural and urban India.

***Acknowledgments***
The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Bohra, N., Srivastava, S., & Bhatia, M. S. (2015). Depression in women in Indian context. *Indian Journal of Psychiatry*, 57, 239-245. doi:10.4103/0019-5545.161485

Denzin, N. K., & Lincoln, Y. S. (2003). *Collecting and Interpreting Qualitative Research*. Thousan Oaks: Sage.

Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches*. San Francisco: Jossey-Bass Publishers.

Kessler, R. C., Berglund , P., Demler , O., & Jin , R. (2003). The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication. *Journal of American Medical Association*. Retrieved October 31, 2016, from https://www.ncbi.nlm.nih.gov/pubmed/?term=Kessler%20RC%5BAuthor%5D&cauthor=true&cauthor_uid=12813115

Lopez, A. D., Mathers, C. D., Ezzati, M., Jamison, D. T., & Murray, C. J. (2006). *Global Burden of Disease and Risk Factors.* New York: Oxford University Press; 2006. Retrieved October 31, 2016, from https://www.ncbi.nlm.nih.gov/books/NBK11812/

Raguram , R., Weiss , M. G., Channabasavanna , S. M., & Devins , G. M. (1996). Stigma, depression, and somatization in South India. *American Journal of Psychiatry*, 8(158), 1043-1049. Retrieved October 31, 2016, from https://www.ncbi.nlm.nih.gov/pubmed/8678173

Stake, R. E. (1995). The Art of Case Study Research. Thousan Oaks, CA: Sage.

Subodh, B. N., Avasthi, A., & Chakrabarti, S. (2008). Psychosocial impact of dysthymia: A study among married patients. *Journal of Affective Disorders*, 199-204.

WHO. (2016). Depression Fact Sheet. Retrieved October 2016, from http://www.who.int/mediacentre/factsheets/fs369/en/

**How to cite this article:** Vishal M (2017), 'I have Depression and others have Anxiety': Cognitive Representation of Depression, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.116/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.117/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Validation of Academic Delay of Gratification Scale among Indian Professional Courses Students

Rajib Chakraborty[1]*

**ABSTRACT**

The present study is an attempt to conduct factor analysis of the Academic Delay of Gratification Scale (ADOGS) for college students, with 10 items, prepared by Bembenutty and Karabenick (1998), on Indian professional courses students. 461 students (256 boys and 205 girls) from engineering, pharmacy, law and education professional courses of Sultan Ul Uloom Education Society, Hyderabad, voluntarily participated in the study, out of which 336 students (190 boys and 146 girls) were part of exploratory factor analysis. With the help of SPSS Statistics Ver.23, Principal Axis Factor extraction method and Varimax rotation, two factors were extracted. Monte Carlo PCA Parallel Analysis was used to settle for one factor explaining 16% variance. The reliability of the instrument using Cronbach's Alpha was found to be 0.715. SPSS Amos Ver. 23 was used to confirm the factor structure and establish within-network construct validity of the instrument using Fit index tests like Chi test p value, DF, CMIN/DF, TLI, CFI, IFI, NFI,RMR and RMSEA from the data of 125 students (66 boys and 59 girls), followed by between network validity based on construct validation approach using Pearson's product moment correlation the data of 136 students (100 boys and 36 girls) measuring their academic delay of gratification and emotional intelligence. There were sufficient evidences to establish that this instrument in its present form can be administered on Indian urban students for the measurement of academic delay of gratification.

***Keywords:*** *Academic Delay of Gratification Scale, Academic Delay of Gratification, Factor Analysis, Exploratory Factor Analysis, Confirmatory Factor Analysis*

**S**tudents pursuing professional courses invest significant amount of time and efforts before realizing their dreams. They are supposed to exhibit "willingness to forgo an immediately available option, in favor of a delayed alternative, in order to secure temporarily distant academic rewards, goals, and intentions" (Bembenutty, 1998).

[1] Asst. Professor, Ghulam Ahmed College of Education, Banjara Hills, Osmania University, Telangana, India
*Responding Author

**Received: February 7, 2017; Revision Received: February 21, 2017; Accepted: February 28, 2017**

This ability is operationally defined as *Academic Delay of Gratification* and its presence in a university student is related to academic success, intrinsic motivation, self efficacy and use of cognitive, meta-cognitive and resource management strategies in studies (Bembenutty, 1998). Even in school students, it is an important component for the promotion of self regulated learning and leads to several desirable outcomes in education (Zhang,. L., Karabenick, S. A., & Lauermann, F. ,2011).

Such an important construct is measured using a 10 item scale for college students prepared by Hefer Bembenutty and Stuart A. Karabenick (Bembenutty,.H. & Karabenick,S.A.,1998). The tool was originally developed in the United States with the American students as sample. Before the tool is administered on students from non-western country like India, its validation through factor analysis is necessary to establish relevance (Markus & Kitaynama, 1991, King and Du, 2011) and hence this study.

## LITERATURE REVIEW

A detailed review of the literature of academic delay of gratification construct and its role in initiating the present study was carried out by the researcher in the previous study (Chakraborty, .R. 2016).

## METHODOLOGY

### *The Study*

A construct validation can be classified as either between-network or within network in type. Within-network construct validation involves factor structure examination using the statistical techniques like exploratory factor analysis, confirmatory factor analysis and reliability analysis of a construct. It is also called as internal construct validation.

In between network construct validity or external construct validation approach, the relationship of the construct with other theoretically related constructs is examined using correlation or regression statistical techniques (March, 1997). In this study, both the approaches are used to establish the validity of academic delay of gratification scale.

First, as part of within-network validation approach exploratory factor analysis is carried out to extract the single factor of ADOG and measure the internal consistency reliability of the instrument when administered on the sample of the study using Cronbach's alpha.

Then, confirmatory factor analysis is carried out to confirm the single factor structure and measure the strength and nature of the correlation between academic delay of gratification and emotional intelligence using Pearson's Product Moment correlation statistical technique.

The researcher in his previous study (Chakraborty,. R., & Prabhakaram, K.S.,2015), proposed that the neural grid between amygdala, prefrontal fortex and ventral striatum can be responsible from the standpoint of Neuroscience for relation between academic delay of gratification and emotional intelligence. This association was found to be positive in nature and weak in strength but significant in secondary school students. The study is repeated on professional courses university students for gaining between-network construct validity evidence of academic delay of gratification. The trait emotional intelligence of the professional courses college students was measured using the *Trait Emotional Intelligence Questionnaire – Adolescent Short Form (TEIQue-ASF,2006),* which is a simplified version of The Trait Emotional Intelligence Questionnaire - Short Form (TEIQUE-SF, Petrides and Furnham, 2004), which consist of 30 items and responses spread across a seven point Likert scale.

***Participants***

461 students (256 boys and 205 girls) from engineering, pharmacy, law and education professional courses of Sultan Ul Uloom Education Society, Telangana, Hyderabad, voluntarily participated in the study, out of which 336 students (190 boys and 146 girls) were part of exploratory factor analysis, and data of 125 students (66 boys and 59 girls) was used for confirmatory factor analysis for within-network construct validity study. The data of 136 students was used in correlation study for between-network construct validity study. All the students received instructions in English throughout their academic life and were fluent in the language.

***Instruments***

1. **Measuring Academic Delay of Gratification**

   The Academic Delay of Gratification scale has 10 items. The scale was prepared based on three criteria. Firstly, every item presented two alternatives to the students, one which provided immediate reward and the other delayed reward. Secondly, both the alternatives resulted in specific outcomes in studies. While the alternative involving the delayed reward increased the possibility of academic success, the other alternative involving instant gratification decreased such a possibility. Thirdly, from the student's point of view, selection of the more delayed reward alternative was more valuable.

   The items covered several academic experiences like "meeting deadlines on assignments, use of the library, interpersonal relations with peers and instructors, and studying course materials". The students responded in a four point Likert-type scale for items like "Go to a favorite concert, play or sporting event and study less for this course even though it may mean getting a lower grade on an exam you will take tomorrow, or Stay home and study to increase your chances of getting a higher grade".

   The four responses are "Definitely choose A", "Probably choose A, Probably choose B, Definitely choose B". The responses are coded from 1 to 4 and the mean score, obtained by dividing the total score by 10 provides the measure of academic delay of gratification. The

higher is the mean score between 1 and 4, the greater is the presence of the trait in the subject.

Factor analysis of the scale during its development revealed two factors from principal component analysis with varimax rotation and Keiser criterion of root one. While items 1, 3,4,5,6,8, presenting choices between academic and non-social alternative activities, loaded on factor 1, items 2,7,9,and 10, presenting choices between academic and social alternatives, loaded on factor 2. Both the factors together explained 47% of variance in the construct. However, the Cronbach's alpha of the tool was obtained as 0.77 which above the generally accepted value of 0.7 for internally consistency. Hence, the use of subscales or the idea of multidimensionality of the construct was dropped and the scale measured only academic delay of gratification from the total score (Bembenutty,.H. & Karabenick,S.A.,1998).

**2. Measuring Emotional Intelligence**

The *Trait Emotional Intelligence Questionnaire – Adolescent Short Form (TEIQue ASF, 2006),* was used to measure the emotional intelligence in adolescent college students. It was derived from the originally prepared instrument by Petrides, K. V., Sangareau, Y., Furnham, A., & Frederickson, N. (2006), to measure emotional intelligence in adults.

The instrument contains 30 items, two from each of the *15 trait EI facets like self esteem, empathy, social awareness, relationships,* which measure global trait EI. The subjects provide the responses on a seven point Likert-type scale, ranging from strongly disagree 1 to strongly agree 7. *The internal consistency* of the original tool was reported to be above 0.80.

The items with positive responses are forward coded and the rest are reverse coded. The mean score can range between 1 and 7 and higher the score greater the presence of trait in the individual.

***Statistical Analysis***

During exploratory factor analysis, the data was not normally distributed as Komolgorov-Smirmov test and Shapiro Wilk's test produced significant results. Hence Principal axis factoring method of extraction was chosen to find the factor structure (Fabrigar et.al., 1999). Parallel analysis is an accurate method to decide the factors to be retained (Velicer and Jackson, 1990). It was used with the help of Monte Carlo PCA Parallel Analysis software. The most common choice of Varimax rotation was selected in this study. The subject to item ratio for determining the sample size was chosen to be 20:1 for getting correct factor structure (Costello and Osberne, 2005). For minimum loading of an item on a factor, the thumb rule of 0.32 was considered (Tabachnick and Fidell, 2001) and a factor with less than three items loading on it was considered weak and the one with five or more was considered strong.

In Confirmatory factor analysis, a good model fit would provide an insignificant result of Chi-square value at a 0.05 threshold (Barrett, 2007). Df and p value must be reported always and

hence included (Kline, 2004 & Hayduk et al, 2007). Chi-square can be significant for a large sample test and show poor fit even though the reality is otherwise, as this test is sensitive to sample size (Gerbing and Anderson,1985). That is why, CMIN/DF is reported which should not be more than 3 for a reasonably good fit (Kline, 2004). Among SEM fit indices, Chi-square is the only inferential statistics. Other goodness of fit tests are RMR, GFI. IFI, TLI, RMSEA CFI. While RMR and RMSEA values are recommended to be below 0.08, the rest of the values are recommended to be above 0.93 (Leech et.al, 2008). These descriptive statistics have only rules-of-thumbs or cut-off values (Iacobucci,.D., 2009) and are used here for providing within-network validity evidence. For providing evidence of between-network validity, the correlation of academic delay of gratification and emotional intelligence is considered. G power software was used for statistical power analysis to determine the sample size for level of significance 0.05, effect size 0.3 (medium) and power 0.9. The software provided the minimum sample size to be 112. A sample size of 136 was actually used in the study. SPSS version 23 provided the nature and strength of the correlation between EI and ADOG using Pearson product moment correlation method. The same software was used for determining the internal consistency measure Cronbach's alpha of the instrument recommended to be above 0.7 for a uni-dimensional set of sample items (Nunnally and Bernstein 1994, Bland and Altman, 1997 & DeVellis, 2003). Cronbach alpha was measured for both EFA and CFA as conducted on fresh samples. It is because " *alpha is a property of the scores on a test from a specific sample of testees",* the researcher should not rely on the published alpha estimates and must measure alpha every time the test is administered on a new sample (Streiner, 2003).

## RESULTS

The Cronbach's alpha of academic delay of gratification scale was found to be 0.715 for a sample size of 336 professional courses students in this study, which is well above the cut-off value of 0.7. It means that the scale is found to be reliable. Exploratory factor analysis, using principal axis factoring extraction method and varimax rotation produced a factor which eigen value 1.619 which is greater than the randomly generated eigen value 1.2751, by Monte Carlo PCA parallel analysis software for 100 iterations. The other eigen value of the second factor extracted was 0.908 less than the second random eigen value 1.1906 of parallel analysis. So, the researcher settled with one factor extraction for academic delay of gratification.

Second sample consisting of 125 students with Cronbach's alpha 0.742 was used for confirmatory factor analysis. Except item 4 (factor loading 0.17) all the items had strong factor loading on ADOG construct (as shown in table table 1), well above the cut-off value of 0.32, *fig*.1.

The chi-test was non-significant with p value at 0.319 for df 35. The CMIN/DF value was 1.097 (less than the cut-off value of 3). The RMR value at 0.069 and the RMSEA value at 0.028 were less than the cut-off value of 0.08. The GFI value was 0.944. The IFI value was 0.981.

***Table 1. Items-Factor Loading – ADOGS***

| Item | Factor Loading |
|---|---|
| 1 | 0.50 |
| 2 | 0.69 |
| 3 | 0.54 |
| 4 | 0.17 |
| 5 | 0.38 |
| 6 | 0.57 |
| 7 | 0.44 |
| 8 | 0.61 |
| 9 | 0.39 |
| 10 | 0.40 |

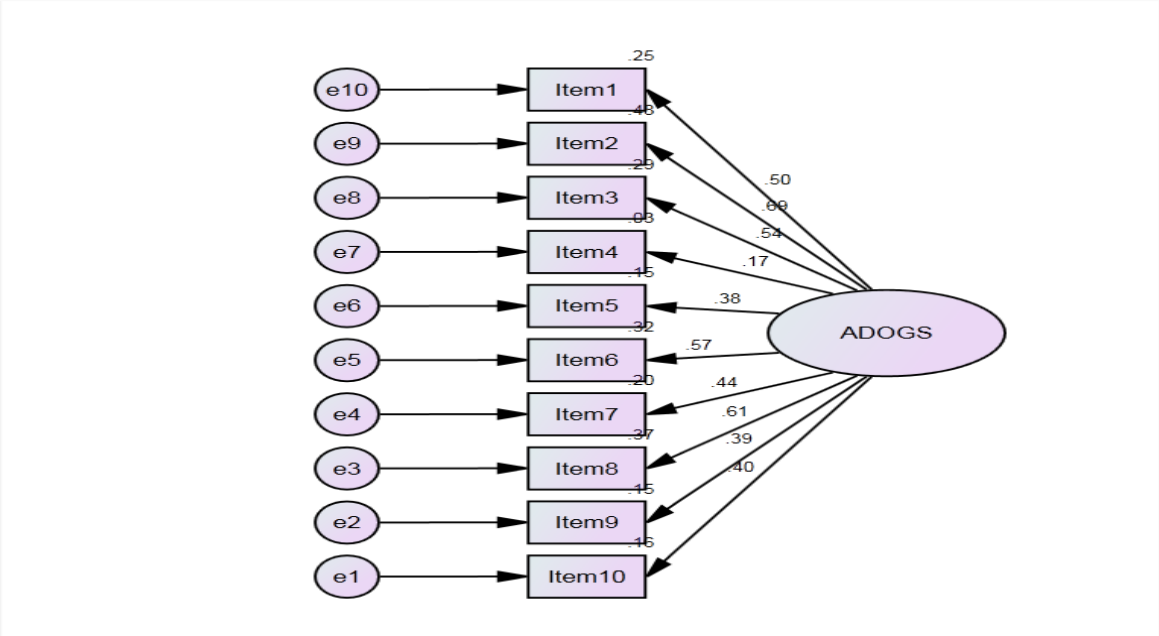



***Fig: 1 Factor Loading of 10 Items on ADOG using SPSS Amos Ver. 23***

The TLI value was 0.974. The CFI value was 0.979. The cut-off value of all the measures of goodness of fit is 0.93. These evidences confirm the single-factor structure of academic delay of gratification as found in the first study by Bembenutty and Karabenick in American context. The use of Cronbach's alpha as the measure of reliability of a unidimensional construct is justified, without the violation of Tau-equivalence model as in this test, each of the 10 items measured the same latent trait, academic delay of gratification, on the same scale ADOGS (Green & Thompson, 2005, Graham, 2005). The acceptable reliability value also confirms the measurement of single latent trait by the scale. It thus establishes the within-network construct validity of the variable's tool, table 2.

For between-network validity, it is hypothesized that for the display of academic delay of gratification as a trait, the presence of emotional intelligence in the persona is called for.

*Table 2. Goodness of Fit Measures for Within – Network Construct Validity*

| Measure | P value | CMIN/DF | RMR | RMSEA | GFI | IFI | TLI | CFI |
|---|---|---|---|---|---|---|---|---|
| **Benchmark** | >0.05 | < 3 | <0.08 | <0.08 | >0.93 | >0.93 | >0.93 | >0.93 |
| **Result** | 0.319 | 1.097 | 0.069 | 0.028 | 0.944 | 0.981 | 0.974 | 0.979 |

To quantify the claim, statistical technique of correlation was carried out on 136 students to express the nature and strength of the relationship between these variables in terms of correlation coefficient r for level of significance 0.05. SPSS ver.23 software provided a result of 0.511, significant at 0.01 level of significance. It means that both the variables are related moderately in strength to each other, very significantly. The coefficient of determination $R^2$ is 0.2611, which means that emotional intelligence can bring in 26.11 % of change in academic delay of gratification or vice-versa.

*Table 3. Correlation between ADOG and EI for Between Network Construct Validity*

| α | Effect Size | Power | Req. Sample Size | Sample Size | r | $R^2$ |
|---|---|---|---|---|---|---|
| 0.05 | 0.3 | 0.9 | 112 | 136 | 0.511* | 0.2611 |

**Correlation in significant at 0.01 level*

Taking the input of power analysis into consideration, like a moderate effect size of 0.3, power 0.9 and level of significance 0.5, one can safely say that there is enough evidence to reject the null hypothesis and accept the alternate hypothesis that there is a relationship between the emotional intelligence and academic delay of gratification in professional courses students which is of medium strength and effect in the population. This establishes between-network construct validity of the instrument, table 3.

## DISCUSSION

The Filipino version by Ganotice Jr, F. A., & King, R. B. (2014)., the Japanese version by Nakanishi, M., Nakaya, M., & Nakanishi, Y. (2015)., Iranian version by Arabzadeh, M., & Kadivar, P. (2012), the Chinese version by King, .R. B., & Du, .H. (2011) of AADOGS are available. The administration of the tool and obtaining of expected results from the tool happened in the case of Korean students (Bembenutty,. H., 2007) as well. The present study tried to validate the tool in Indian context.

The sample size was more than 1:20 ratio of subject to item. The reliability of the instrument was acceptable when administered on a sample of 336 subjects. Exploratory factor analysis extracted two factors when principal factor analysis extraction method along with varimax rotation was employed. However, parallel analysis finally revealed single factor dimensionality of the construct. To confirm the same, confirmatory factor analysis was carried out on another 125 subjects in the sample. Except item 4, all the items loaded significantly on the construct. A host of goodness of fit measures was selected to confirm the single factor structure and they provided sufficient evidence for the same, under within-network construct validity approach. The

construct academic delay of gratification, as hypothesized, was found to be very significantly and in moderate strength be related to emotional intelligence. The result has medium effect size of 0.3 level of significance 0.05 and power of 0.9 under power analysis, providing evidence for between-network construct validity. Since the single dimension factor structure, acceptable Cronbach alpha reliability and construct validity are displayed by the instrument, it can be used in its present form on Indian urban adolescent college students to measure their academic delay of gratification trait.

However, further studies on validation of the tool must be carried out on students of academic courses at under graduation and post graduation levels in different states of a culturally diverse country like India. In such a scenario, the tool's version in the local language must be prepared by seeking the help of regional language experts involving cross-validation technique.

***Acknowledgments***
The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Arabzadeh, M., & Kadivar, P. (2012): "Examination Of Reliability, Validity, And Factor Analysis Of Academic Delay Of Gratification Scale", *Training Measurement*, Fall, Volume 3 , Number 9, pp. 1 - 17.

Barrett, P. (2007), "Structural Equation Modelling: Adjudging Model Fit," *Personality and Individual Differences*, 42 (5), 815-24.

Bembenutty,. H.(2007), "Self-Regulation of Learning and Academic Delay of Gratification among Korean College Students", Online Submission, Paper presented at the *Annual Meeting of the American Educational Research Association*, Chicago, IL.

Bembenutty,.H., (2007), "Self-Regulation of Learning and Academic Delay of Gratification: Gender and Ethnic Differences Among College Students", *Journal of Advanced Academics*, Vol.18, No.4, pp.586-616.

Bembenutty,. H., (2009), "Test anxiety (evaluation) and ADOG (Educational Aspects), *"College Student Journal*, Project Innovation (Alabama) ISSN: 0146-3934.

Bembenutty,. H., Karabenick, S. A.,(1998),"Academic Delay of Gratification", *Learning and Individual Difference*, Volume 10, Number 4, 1998, pages 329-346, ISSN: 1041-6080.

Bland, .J, Altman, .D. (1997), *"Statistical Notes: Cronbach's Alpha"*, BMJ, 314:275.

Chakraborty, .R., (2016), " A Narrative Review of the Literature on Academic Delay of Gratification Construct", *iJARS International Journal of Humanities and Social Studies*, Volume II, Issue 4, ISSN: 2455-1465 (July/Aug-2016),
DOI: 10.20908/ijarsijhss.v2i4.11195.

Chakraborty,.R., & Prabhakaram, K.S. (2015), "A Study on the Relationship Between Delay of Gratification and Emotional Intelligence in Secondary School Students", *iJARS International Journal of Humanities and Social Studies*, 1(1).

Costello, A.B, & Osborne, J.W. (2005), "Best Practices in Exploratory Factor Analysis: Four Recommendations for Getting the Most from your Analysis", *Practical Assessment, Research and Evaluation*, 10(7).

DeVellis,.R., (2003), *"Scale development: Theory and Applications"*, Thousand Okas, CA: Sage.

Fabrigar, L. R., Wegener, D. T., MacCallum, R. C., & Strahan, E.J. (1999), "Evaluating the use of exploratory factor analysis in psychological research", *Psychological methods*, 4(3), 272-299.

Ganotice Jr, F. A., & King, R. B. (2014)., "Blessed are those who wait: Validating the Filipino version of the Academic Delay of Gratification Scale (ADOGS)", *The Asia-Pacific Education Researcher*, 23(1), 19-27.

Gerbing, D. W., & Anderson, J. C. (1985)," The effects of sampling error and model characteristics on parameter estimation for maximum likelihood confirmatory factor analysis", *Multivariate Behavioral Research*, 20, 255−271.

Graham J. ,(2006), "Congeneric and (Essentially) Tau-Equivalent estimates of score reliability: what they are and how to use them", *Educational Psychological Measurement*, 2006;66:930-44.

Green S, Thompson M.(2005)," *Structural equation modeling in clinical psychology research*", In: Roberts M, Ilardi S, editors. Handbook of research in clinical psychology. Oxford: Wiley-Blackwell.

Hayduk, L., Cummings, G.G., Boadu, K., Pazderka-Robinson, H., and Boulianne, S. (2007), "Testing! Testing! One, Two Three – Testing the theory in structural equation models!," *Personality and Individual Differences*, 42 (2), 841-50.

Iacobucci,D. (2010), "Structural Equations Modeling: Fit Indices, sample size, and advanced topics*", Journal of Consumer Psychology* 20, pp. 90–98.

King, .R. B., & Du, .H. (2011), "All Good Things Come to Those Who Wait: Validating the Chinese Version of the Academic Delay of Gratification Scale (ADOGS)" *The International Journal of Educational and Psychological Assessment* Vol. 7 Iss. 1.

Kline, R.B. (2004), "*Principles and Practice of Structural Equation Modelling*" (2nd Edition ed.). New York: The Guilford Press.

Leach, C. W., van Zomeren, M., Zebel, S., Vliek, M. L. W., Pennekamp, S. F., Doosje, B., Ouwerkerk, J. W., & Spears, R. (2008), "Group-level self-definition and self-investment: A hierarchical (multicomponent) model of in-group identification", *Journal of Personality and Social Psychology*, 95(1), 144-165.

Markus, H. R. & Kitayama,S.(1991), "Culture and Self: Implications for cognition, emotion and motivation", *Psychological Review*, 98, 224-253.

Marsh, H.W.(1997), "The measurement of physical well-concept: A construct validation approach", In. K. Fox (Ed.), The physical self concept: From motivation to well-being (pp 27-58), *Champaign, IL: Human Kinetics.*

Nakanishi, M., Nakaya, M., & Nakanishi, Y. (2015)., "Development of the Japanese Version of the Academic Delay of Gratification Scale for Undergraduate Students", *Japanese Journal of Personality*, 23(3),pp.197-200.

Nunnally J, Bernstein L.(1994), *"Psychometric theory"*, New York: McGraw-Hill Higher, INC; 1994.

Petrides, K. V., Sangareau, Y., Furnham, A., & Frederickson, N. (2006), "Trait emotional intelligence and children's peer relations at school. Social Development", 15, 537-547.

Ronnel B King and Hongfei Du (2011), "All Good Things Come to Those Who Wait: Validating the Chinese Version of the Academic Delay of Gratification Scale (ADOGS)" *The International Journal of Educational and Psychological Assessment*, 7 (1).

Streiner D.,(2003), "Starting at the beginning: an introduction to coefficient alpha and internal consistency*"*, *Journal of personality assessment*. 2003;80:99-103.

Tabachnick, B.G., & Fidell, L.S. (2001), "*Using Multivariate Statistics"*, Boston: Allyn and Bacon.

Velicer, W.F.,& Jackson, D.N.(1990), "Component Analysis Versus Common Factor Analysis – Some Future Observations", Multivariate Behavioral Research, 25(1), 97-114.

Zhang,.L., Karabenick, S. A., & Lauermann, F. (2011), "Academic delay of gratification and children‟s study time allocation as a function of proximity to consequential academic goals",. *Learning and Instruction*, 21(1), 77-94.

**How to cite this article:** Chakraborty R (2017), Validation of Academic Delay of Gratification Scale among Indian Professional Courses Students, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.117/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.118/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Analysis of Well Being of People Practicing Yoga

K. Madhava Chandran[1]*

## ABSTRACT

***Background:*** De-stressing for achieving a sense of well being has become an absolute necessity for people to reduce psycho-somatic disorders. The degree to which one experiences control over one's response to life events will have a buffering effect for adverse life events and will enhance wellbeing. Subjective wellbeing indicates how people evaluate their lives in terms of feelings of wellbeing or the lack of it. Yoga helps in significant reduction of stress, contributing to a feeling of better wellbeing. ***Aim:*** This study analyses the effect of yoga on subjective well being of people. ***Research Design:*** Survey method was adopted for the study. ***Sample:*** Consisted of 100 randomly selected yoga practitioners. ***Tools used:*** They were interviewed using a questionnaire consisting of 13 subjective well being parameters (OECD, 2013), with three responses, scored as 3, 2 and 1. Subjective Well Being Index (SWBI) was worked out as the sum of the scores of the parameters. The data was analyzed through analysis of variance. ***Results:*** The mean SWBI of yoga practitioners mostly improves with the years of yoga practice. However, even up to two years of yoga practice contributes to a very promising condition of well being, with more than 89% of the respondents experiencing either very much or slight improvement / reduction in all the well being parameters. More than 10 years of yoga practice gives the maximum SWBI of 37, equivalent to about 95% of the maximum possible index, while 6 to 10 years of yoga contributes to an index of about 34. Even though the SWBI of up to 2 years, 2 to 4 years and 4 to 6 years of yoga practice are statistically on par, they differ significantly from that of the yoga practice categories above 6 years. 6 to 8 years and 8 to 10 years of yoga contribute to SWBI, which is also significantly different from the SWBI of more than 10 years practitioners. ***Conclusion:*** The results of the study establish the effect of yoga in achieving a feeling of well being among people, which would ultimately contribute to better physical health also for them. Hence, psycho-somatic disorders existing under the fast, hectic and tense conditions in the society can be reduced considerably through the practice of relaxation techniques such as yoga. In this context, it will be worthwhile if institutions such as yoga centres, recreational clubs, residents' associations, schools, offices etc. take initiative in popularizing such mind - body relaxation

[1] Ph.D, Trust Member of the Patanjali Yoga Research Centre, Kozhikode, Kerala, India
*Responding Author

**Received: February 1, 2017; Revision Received: February 21, 2017; Accepted: February 28, 2017**

techniques through awareness programs which also include information from research carried out, demonstration of the techniques etc. with the objective of creating a healthy society.

***Keywords:*** *Stress, Subjective well being, Yoga*

**P**eople find it difficult to adjust under the fast, hectic and stressful conditions of life, resulting in health problems and consequent medical treatment with harmful drugs. De-stressing for achieving a sense of well being is the need of the hour in the society in order to reduce psycho-somatic disorders. Personal wellbeing has been conceptualized as optimal functioning rather than merely absence of pathology. Research into wellbeing has centered on the term subjective wellbeing, measured by overall satisfaction with life and by satisfaction across various life domains. The degree to which one experiences control over one's response to life events (perceived control) is considered to have a buffering effect for adverse life events and will enhance wellbeing. Subjective wellbeing indicates how people evaluate their lives in terms of feelings of wellbeing or the lack of it.

Yoga is considered to be one of the effective tools available to overcome various physical and mental problems. Yoga aims at an integrated and harmonious development of all the potentialities of man, with significant reduction in stress, and consequently, better feeling of wellbeing. Yoga is reported to have a positive effect on mood, stress, anxiety, depression, mindfulness and other quality of life measures (Michalsen et al., 2005; Granath et al, 2006; Oken et al., 2006). The influence of yoga and meditation on subjective wellbeing of people have been reported (Gopukumar and Hussain Ali, 2002; Kamakhy Kumar, 2004). The effect of yoga on subjective wellbeing would result from its impact on health, purpose in life and perceived control. Setterlind (1983) reported the effect of meditation in bringing a positive change in the well-being of subjects. Malathi et al. (2000) observed a significant improvement in majority of the subjective well-being factors in healthy volunteers after four months of yoga practice.

***Objective***

1. This study was carried out in order to analyze the effect of yoga on subjective well being of people.

## METHODOLOGY

A random sample of 100 people, who practice yoga learned from Patanjali Yoga Research Centre, Kozhikode District, Kerala State, India, was selected for the study. The sample consisted of people practicing yoga for a period of up to ten years and above. They were interviewed using a questionnaire consisting of 13 subjective well being parameters (OECD, 2013). The responses to improvement / reduction in the parameters through the practice of yoga, namely, very much, slight, no improvement / reduction were scored as 3, 2 and 1 respectively. The total score of the parameters was worked out as the subjective well being index of the respondent. The data was

analyzed through analysis of variance (ANOVA). The data has been presented in the paper as percentages and scores / index.

## RESULTS

The data on subjective well being parameters and index has been presented under different periods of yoga practice, starting from up to two years to more than 10 years. The Analysis of Variance (ANOVA) for the mean scores of various parameters under different periods of yoga practice is shown in Table 1. Table 2 shows the ANOVA for the mean subjective well being index of various yoga practice categories.

***Table 1. ANOVA of subjective well being parameter scores***

| Duration of yoga practice (years) | Mean score for happiness | Mean score for calmness | Mean score for relaxation | Mean score for life enjoyment | Mean score for tiredness | Mean score for tension | Mean score for loneliness |
|---|---|---|---|---|---|---|---|
| Up to 2 | 2.50 | 2.38 | 2.44 | 2.31 | 2.38 | 2.50 | 2.68 |
| 2 - 4 | 2.75 | 2.25 | 2.58 | 2.50 | 2.33 | 2.42 | 2.25 |
| 4 - 6 | 2.89 | 2.56 | 2.89 | 2.22 | 2.22 | 2.00 | 3.00 |
| 6 - 8 | 2.33 | 3.00 | 2.33 | 3.00 | 3.00 | 3.00 | 2.67 |
| 8 - 10 | 2.60 | 2.80 | 2.40 | 3.00 | 3.00 | 2.80 | 2.60 |
| > 10 | 3.00 | 2.60 | 3.00 | 2.80 | 3.00 | 2.60 | 3.00 |
| | F = 1.498 Sig. $p < 0.20$ | F = 1.625 Sig. $p < 0.20$ | F = 1.545 Sig. $p < 0.20$ | F = 3.02 Sig. $p < 0.01$ | F = 3.995 Sig. $p < 0.01$ | F = 2.824 Sig. $p < 0.05$ | F = 2.073 Sig. $p < 0.10$ |

***Table 2. ANOVA of subjective well being index of the yoga practitioners***

| Duration of yoga practice (years) | Mean subjective well being index (SWBI) |
|---|---|
| Up to 2 | 31.35 |
| 2 - 4 | 32.17 |
| 4 - 6 | 32.11 |
| 6 - 8 | 34.33 |
| 8 - 10 | 34.20 |
| > 10 | 37.00 |
| F = 2.494 Sig. $p < 0.05$ CD = 1.68 | |

Table 3 gives the proportion of yoga practitioners reporting very much improvement / reduction in subjective well being parameters. Reduction applies to tiredness, tension, worry, anger and loneliness only. ANOVA of the percentage of respondents reporting very much improvement / reduction in various parameters under two categories of yoga practice, namely, up to 2 years and more than 2 years is shown in Table 4.

***Table 3. Respondents reporting very much improvement / reduction in subjective well being parameters through yoga practice***

| Sl. No. | Subjective well being parameter | Respondents (%) reporting very much improvement / reduction* in the parameter with | |
|---|---|---|---|
| | | Up to 2 years yoga practice | > 2 years yoga practice |
| 1 | Happiness | 64.2 | 77.3 |
| 2 | Contentment | 71.4 | 90.9 |
| 3 | Calmness | 33.3 | 68.2 |
| 4 | Relaxation | 57.1 | 72.7 |
| 5 | Enjoyment in life | 42.9 | 63.6 |
| 6 | Enthusiasm | 60.7 | 68.2 |
| 7 | Concentration | 39.3 | 50.0 |
| 8 | Memory | 42.9 | 50.0 |
| 9 | Tiredness | 35.7 | 72.7 |
| 10 | Tension | 46.4 | 50.0 |
| 11 | Worry | 32.1 | 45.5 |
| 12 | Anger | 39.3 | 31.8 |
| 13 | Loneliness | 64.2 | 86.4 |

**Reduction applies to the parameters, namely, Tiredness, Tension, Worry, Anger and Loneliness*

***Table 4. ANOVA of respondents reporting very much improvement / reduction in subjective well being parameters through yoga practice***

| Years of yoga practice | Respondents (%*) reporting very much improvement / reduction in subjective well being parameters | F |
|---|---|---|
| Up to 2 | 47.7 | 9.23 |
| > 2 | 65.9 | Sig. $p < 0.01$ |

**Mean percentage considering all the subjective well being parameters*

Table 5 and 6 respectively show the proportion of yoga practitioners experiencing slight improvement / reduction in subjective well being parameters, and ANOVA of the percentage of respondents reporting slight improvement / reduction in various parameters under two categories of yoga practice, namely, up to 2 years and more than 2 years

***Table 5. Respondents reporting slight improvement / reduction in subjective well being parameters through yoga practice***

| Sl. No. | Subjective well being parameter | Respondents (%) reporting slight improvement / reduction* in the parameter with | |
|---|---|---|---|
| | | Up to 2 years yoga practice | > 2 years yoga practice |
| 1 | Happiness | 32.1 | 22.7 |
| 2 | Contentment | 25.0 | 09.1 |
| 3 | Calmness | 63.0 | 31.8 |
| 4 | Relaxation | 35.7 | 27.3 |
| 5 | Enjoyment in life | 53.6 | 36.4 |
| 6 | Enthusiasm | 28.6 | 31.8 |
| 7 | Concentration | 53.6 | 50.0 |
| 8 | Memory | 53.6 | 50.0 |
| 9 | Tiredness | 64.3 | 22.7 |
| 10 | Tension | 53.6 | 45.5 |
| 11 | Worry | 64.3 | 40.9 |
| 12 | Anger | 53.6 | 59.1 |
| 13 | Loneliness | 27.3 | 13.6 |

**Reduction applies to the parameters, namely, Tiredness, Tension, Worry, Anger and Loneliness*

***Table 6. ANOVA of respondents reporting slight improvement / reduction in subjective well being parameters through yoga practice***

| Years of yoga practice | Respondents (%*) reporting slight improvement / reduction in subjective well being parameters | F |
|---|---|---|
| Up to 2 | 46.8 | 4.87 |
| > 2 | 33.9 | Sig. $p < 0.05$ |

**Mean percentage considering all the subjective well being parameters*

## DISCUSSION

When comparing the subjective well being of people based on period of yoga practice through analysis of variance, the F value is found to be significant for the difference in mean score of the parameters, namely, happiness, calmness, relaxation, enjoyment in life, tiredness, tension and loneliness (Table 1). It can also be seen that, for happiness, relaxation, tiredness and loneliness, the maximum score of 3 (indicating very much improvement / reduction in the parameter) is observed for all the respondents having more than 10 years of yoga practice. Life enjoyment also shows a very high score of 2.80 for this group.

It can be made out from Table 2 that the mean subjective well being index of yoga practitioners is mostly improving with the years of yoga practice. More than ten years of yoga practice gives an index of 37, equivalent to about 95% of the maximum possible index of 39, while 6 to 10 years of yoga contributes to an index of about 34, which is equivalent to about 88% of the

maximum possible index. The analysis of variance is significant at $p < 0.05$ (Table 2). Considering the CD value of 1.68 (Table 2), it can be inferred that up to 2 years of yoga practice gives a subjective well being Index (SWBI), which is significantly different from that of the respondents having 6 to 8 years, 8 to 10 years and more than 10 years of yoga practice. Similarly, 2 to 4 years contributes to a SWBI, which is significantly different from the SWBI of 6 to 8 years, 8 to 10 years and more than 10 years categories. 4 to 6 years shows a SWBI, which is significantly different from 6-8 years, 8 to 10 years and more than 10 years. 6 to 8 years and 8 to 10 years of yoga practice contribute to a SWBI, which is significantly different from the SWBI of people practicing yoga for more than 10 years (Table 2).

It may be inferred from the CD value shown in Table 2 that there is no statistically significant difference in SWBI of people falling within various yoga practice categories up to 6 years. Similarly, the SWBI of 6 to 8 years and 8 to 10 years also do not differ significantly.

It may be noted that even up to 2 years of yoga practice is contributing to a very promising condition of well being for people, since the SWBI of this category of yoga practitioners is 31.35 (Table 2), which is equivalent to about 80% of the maximum possible subjective well being index. The maximum index will be obtained only when the yoga practitioner is able to achieve very much improvement / reduction for all the well being parameters. Similarly, even though there exists statistically significant difference in the proportion of people experiencing very much improvement / reduction in subjective well being parameters between up to 2 years and more than 2 years yoga practice categories (Table 4), it can be made out from the data presented in Tables 3 and 5 that, more than 89% of people, who have practiced yoga for a period of up to 2 years, experience either very much or slight improvement / reduction in all the well being parameters. This is a positive trend, indicating that lesser period of yoga practice can also help the practitioner in attaining a good sense of well being. This information could help in correcting the outlook of some people, who feel that a very long period of yoga practice is required to attain benefits (personal observation of the author)

The analysis of variance of the percentage of respondents reporting slight improvement / reduction in the subjective well being parameters under up to 2 years and more than 2 years yoga categories also shows a significant F value, even though comparatively more people report so under the first than the second category (Table 6). This is because more number of people with more than 2 years yoga experience (second category) have reported very much improvement / reduction in the subjective well being parameters, when compared to up to 2 years (Table 4)

## CONCLUSIONS

The results of this study confirm the effect of yoga in achieving a feeling of well being among people, which is in line with similar studies carried out by other researchers. This will also contribute to better physical health, considering the fact that the lack of wellness and peace at the

mental level is an important factor influencing the incidence of many diseases. Hence, the occurrence of many psycho-somatic disorders in our society can be reduced considerably through the practice of relaxation techniques such as yoga. This assumes relevance in the present day context, where people mostly lead a fast, hectic and tense life as an outcome of the unavoidable necessities of family / social commitments, work pressure etc. In this context, it will also be worthwhile if institutions such as yoga centres, recreational clubs, residents' associations, schools, offices etc. take initiative in popularizing such mind - body relaxation techniques through awareness and demonstration programs. which should also include information generated from research carried out, with the objective of creating a healthy society.

***Acknowledgement***

I would like to express my sincere gratitude to Sri. Unniraman, P., Yogacharya and Director of Patanjali Yoga Research Centre, Kozhikode, Kerala, India for giving me the opportunity to conduct this study. I also appreciate his noble endeavour to promote the yoga centre as a research institution by carrying out studies on yoga, meditation etc.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Gopukumar, K., and Hussain Ali, M. (2002). "Meditation – A harbinger of subjective well-being", *Journal of Personality and Clinical Studies*, 19: 93 to102

Granath, J., Ingvarsson, S., von Thiele, U., and Lundberg, U. (2006). "Stress management: A randomised study of cognitive behavioural therapy and yoga", *Cognitive Behaviour Therapy*, 35(1): 3 to 10

Kamakhya, K. (2004). "Yoga nidra and its impact on students well-being", *Yoga Mimamsa*, 36: 71 to 76

Malathi, A., Damodaran, A., Shah, N., Patil, N. and Maratha, S. (2000). "Effect of yogic practices on subjective well-being", *Indian Journal of Physiology and Pharmacology*, 44: 202 to 206

Michalsen, A., Grossman, P., Acil, A., Langhorst, J. and Ludtke, R., Esch, T., et al. (2005). "Rapid stress reduction and anxiolysis among distressed women as a consequence of a three-month intensive yoga program", *Medical Science Monitor*, 11(12): 555 to 561

OECD (2013). *OECD Guidelines for Measuring Subjective Wellbeing.* OECD Publishing, Accessed from http://dx.doi.org/10.1787/9789264191655- en (December 21, 2015)

Oken, B.S., Zajdel, D., Kishiyama, S., Flegal, K., Dehen, C., Haas, M., et al. (2006). "Randomized, controlled, six-month trial of yoga in healthy seniors: Effects on cognition and quality of life", *Alternative Therapies*, 12(1): 40 to 47

Setterlind, S. (1983*). "Relaxation training in School: Review of research and empirical studies"*, Goteborg, Sweden: Acta Universities Gothoburgensis

**How to cite this article:** Chandran M (2017), Analysis of Well Being of People Practicing Yoga, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.118/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.119/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Psychological Well-Being as a Correlate of Physical Well-Being among the Spouses of Indian Armed Force Personnel

Bisht Prachi[1]*, Pande Lata[2]

**ABSTRACT**

Armed force is an organization where the process of deployment of soldiers or military personnel occurs very frequently. The soldiers are frequently deployed in either active field areas, high altitude areas and routine exercise because of which the families has to face separation for longer as well as for short duration influencing them emotionally, psychologically and mentally leading to stress responses, such as anger, irritability, sleeplessness, and anxiety, and significant levels of distress (Demers 2009) and triggers depression, anxiety, decreased marital satisfaction and stress among the wives of the military personnel and this may even lead to somatization. Therefore the present study establishes the correlation between the psychological well-being and physical health of the wives of Indian soldiers and intend to find how different dimensions of each variable influences each other showing the interaction of the dimensions of psychological well-being and physical health. Total 300 spouses were selected as respondents. Correlation analysis was used as statistical tool. The results of the analysis show significant and positive correlation between the psychological well-being and physical health.

***Keywords:*** *Deployed, Non-Deployed, Psychological-Wellbeing, Stress, Mental Health*

Today every Indian citizen is well versed with the tension prevalent between India and Pakistan regarding the years old Kashmir issue. Recently the relations between the two countries have become even worse after the 'Uri Attack' by the terrorists followed by the 'Surgical Strike' done by Indian army. Because of series of encounters and attacks from the side of both the countries so many soldiers martyred their lives to safeguard their nation's security and pride. What the families (especially spouses) of the martyred soldiers have been through are beyond our imagination. These conditions bring a great challenge to the families of the soldiers who are deployed to high insurgency areas or to the areas of hard climatic conditions. The stressors are not only present during the periods of deployments but could also be present during the periods

[1] Phd Research Scholar, Deptt of Home Science D.S.B Campus, Kumaon University, Nainital, India
[2] Professor, HOD of Dept. of Home Science D.S.B Campus, Kumaon University, Nainital, India
*Responding Author

**Received: February 10, 2017; Revision Received: February 23, 2017; Accepted: February 28, 2017**

of non-deployments as apart from deployments other activities like frequent relocation from one military station to another, regular moves, short duration stay in one location and dual parenting roles that are projected onto the spouse, make it hard for the spouses who are well qualified, to maintain a stable career leaving them mentally as well as physically fatigued. Military wives also suffer from considerable unemployment, underemployment and low earnings **Jacquelyn S (1990).** Army wives are completely supportive of their husband's military career and subordinate their own career development to that of their husbands, this attitude is changing, especially among younger, highly educated **(Braddy, 1988).**Aspects of the military lifestyle such as frequent relocations explain many of the employment outcomes observed among wives of military personnel. It appears that consideration of the spouse's career is becoming more important in retention decision making in military families.

These situations trigger depression, anxiety, decreased marital satisfaction and stress among the wives of the military personnel that hampers overall well being and may even lead to somatization. Psychological distress that spouse of military soldiers develops with time that include mental states of depression and anxiety and gradually these mental states may lead to physical symptoms like high blood pressure, hypertension and even more worse forms of somatization such as cardiovascular diseases, diabetes and atherosclerosis etc. may arise as a result completely ruining the physical heath of the person. Physical health is important for overall well-being and is the most visible of the various dimensions of health, which also include social, intellectual, emotional, spiritual and environmental health. Health and wellness play a vital role in encouraging individuals to engage with a wide range of activities that could contribute to the development and growth of individuals at every stage of life. Thus, health and wellness also provides internal and external resources to individuals involved and develop a healthy life **(Donatelle 2001).**Therefore if physical health is jeopardized then it is ultimately going to hamper the overall well being of the individual and ultimately its impact is seen in the society. The relationship between health and wellbeing is not just one-way. Health influences wellbeing and wellbeing itself influences health. Positive wellbeing is related to physical health, aspects of wellbeing such as happiness and optimism are related to longer life, decreased risk of illness and to increased resistance to illness **(Lyubomirsky *et al* 2005 and Veenhoven 2008).**

## MATERIAL AND METHODS

Women of reproductive age group of 18 to 45 years were the target of the study. Five regiments posted in Suratgrah military station Rajasthan, was selected by random sampling 50 women from each group (deployed and non-deployed) was selected based on the selected criteria i.e. age, husband's rank and husband's deployment and non-deployment. Therefore comprising a sample of 300 spouses (100 officers' spouses,100 JCOs' spouses and 100 ORs' spouses).Assessment of psychological well-being was done by standardized scale developed by **Sisodia and Bhatnagar (2013**). The scale assesses psychological wellbeing in 5 areas that includes Satisfaction,

Efficiency, Sociability, Mental Health and Interpersonal Relation. Physical health was assessed using self developed and statistically pre-tested physical health scale. The scale assesses physical well-being in 4 areas that include nutritional status, micronutrient deficiency status, general physical health and lifestyle.

## RESULTS AND DISCUSSION

***Table 4.7.3 Correlation of different aspects of psychological well being and physical health of total respondents***

| Physical health of the respondents | Psychological well being of the respondents | | | | | |
|---|---|---|---|---|---|---|
| | Life satisfaction | Efficiency | Sociability | Mental health | Interpersonal relationship | Total |
| **Nutritional Status** | 0.179 | **0.430**** | 0.116 | **0.272**** | 0.398 | **0.303**** |
| **Micronutrient Deficiency** | **0.321**** | **0.370**** | 0.118 | **0.327**** | **0.379**** | **0.382**** |
| **General health status** | 0.106 | **0.224*** | 0.144 | **0.135**** | 0.129 | 0.121 |
| **Lifestyle** | **0.283**** | **0.271**** | 0.100 | **0.238**** | **0.241*** | **0.296**** |
| **Total Physical Health** | **0.337**** | **0.439**** | 0.128 | **0.331**** | 0.387 | **0.375**** |

***1: Correlation of different aspects of psychological well being and physical health of total respondents***

The correlation of different aspects of psychological well-being and physical health of total respondents (spouses of Indian military personnel) is depicted in the table 1.The co-relational analysis of the dimensions of physical health and psychological well-being brings out the fact that nutritional status(r=0.303;p=0.01),micronutrient deficiency status( r=0.382;p=0.01),lifestyle (r=0.296;p=0.01) and overall physical health (r=0.375;p=0.05) was positively and significantly correlated with overall psychological well-being of the spouses of Indian military personnel. As far as the interaction of the components of physical health and psychological well-being is concerned it was observed that nutritional status had a statistically significant and positive correlation with efficiency (r=0.430; p=0.01) and mental health (r=0.272; p=0.05) however it also had a positive correlation with life satisfaction, sociability and interrelationship but the correlation was statistically non-significant. Micronutrient status was found to have a positive and statistically significant correlation with life satisfaction(r=0.321; p=0.01), efficiency (r=0.370; p=0.01), mental-health (r=0.327; p=0.01) and inter relationship (r=0.379; p=0.01) but had non-significant correlation with sociability but the direction of correlation positive. Next dimension i.e. general physical health status was found having a positive and statistically significant correlation with efficiency (r=0.236; p=0.05) and mental health (r=0.236; p=0.05) which is also found by **Aromaa *et al* (1994)** that the risk of CVD death and coronary death was elevated in depressed persons in a study to review the associations between depression and

cardiovascular diseases, and positive but non-significant correlation with the rest of the dimensions i.e. life satisfaction, sociability and interpersonal relationships. Lifestyle had a positive correlation with life satisfaction (r=0.283; p=0.01), efficiency(r=0.271; p=0.01), mental health(r=0.238; p=0.01) and interpersonal relationship (r=0.241; p=0.05) and just dimension i.e. sociability had a non-significant correlation with lifestyle though the direction of correlation was positive. Overall physical health was found to be positively correlated with life satisfaction(r=0.337; p=0.05), efficiency (r=0.439; p=0.05), mental health (r=0.331; p=0.05) but non-statistically correlated in a positive direction with sociability and interpersonal relationship.

Finally, correlation analysis revealed the fact that physical health was positively and significantly correlated(r=0.375; p=0.05) with the psychological wellbeing among the spouses of Indian military personnel that means that physical health gets better with increasing psychological well-being and vice versa which is supported by a study conducted by **Moussavi et al (2007)** who indicated that that depression is an important public-health problem, and one of the leading causes of disease burden worldwide. Depression is often co-morbid with other chronic diseases and can worsen their associated health outcomes. Depression produces the greatest decrement in health compared with the chronic diseases angina, arthritis, asthma, and diabetes. The co-morbid state of depression incrementally worsens health compared with depression alone, with any of the chronic diseases alone, and with any combination of chronic diseases without depression.

## CONCLUSION

The present study establishes the correlation between the dimension of psychological well-being and physical well-being. In view of the above discussion it could be inferred that psychological well being and physical health go hand in hand, to stay physically fit it is very much important that one must be in a state of psychological well being not in the state of psychological distress. The results conclude the fact that overall psychological well-being and all the dimensions of psychological well-being except general physical well-being is significantly and positively correlated with the dimensions of physical well-being. This proves the fact that different phases of deployment (pre-deployment and post-deployment) shatters a women's psychological well-being due to many contributing factors like loneliness, fear related husband's safety, anticipation of work load, anxiety etc that hampers her physical well-being to a prominent extent. Therefore proper counseling centers and more facilities should be extended to this section of women for their better psychological and physical well-being.

***Acknowledgments***

The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Aromaa A, Raitasalo R, Reunanen R, Impivaara O, Heliovaara M, Knekt P, Lehtinet V ,M. Joukamaa M, Maatela J(1994) Depression and cardiovascular diseases. *Acta Psychiatria scandinavica*. 89(3) 77–82.

Braddy, B. A. (In preparation). Exploratory discussions of spouse employment issues.(Research Product 90-06). Alexandria, VA: *U.S. Army Research Institute for the Behavioral and Social Sciences.*

Demers A (2008) The war at home: Consequences of loving a veteran of the Iraq and Afghanistan Wars: *Intr J Med Health*. 6(1):44

Donatelle 2001. *Health: the basics*. 4th ed. Boston:Allyn & Bacon

Jacquelyn Scarville (1990) U.S. Army Research Institute N for the Behavioral and Social Sciences Research Report 1555 Spouse Employment in the Army: Research Findings DTIC ELEC T ED March 1990

Lyubomirsky, S., King, L. & Diener, E. (2005). The benefits of frequent positive affect: Does happiness lead to success? *Psychological Bulletin*. 131-6, 803-855.

Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V and Ustun B (2007) Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *The Lancet*.370:851-58.

Sisodia D S and Chaudhary P (2005) *Psychological well-being Scale*. National psychological Coorporation, Agra.

Veenhoven, R. (2008) Healthy happiness: Effects of happiness on physical health and the consequences for preventive health care. *J happiness studies.* 9, 3, 449-469.

**How to cite this article:** Prachi B, Pande L (2017), Psychological Well-Being as a Correlate of Physical Well-Being among the Spouses of Indian Armed Force Personnel, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.119/20170402, ISBN:978-1-365-78192-6

The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 2, No. 92, DIP: 18.01.120/20170402
ISBN: 978-1-365-78192-6
http://www.ijip.in | January-March, 2017

# Problem Solving In Mathematics-Role of Worked Examples in Reducing Cognitive Load and Improving Scholastic Performance

D. Venkateshwar Rao[1]*

**ABSTRACT**

Mathematics is a compulsory subject at school level across the globe. It is also considered as a difficult subject. Reducing the cognitive load and improving the scholastic performance are the main concerns in the teaching learning process of mathematics. The present study is an attempt in this direction by using cognitive load theory. The study is intended to analyze the role of worked examples in learning mathematics and to design and conduct an intervention to reduce the cognitive load and improve the performance of students in mathematics. Sample comprised of 76 students of 6th grade. The sample was divided in to two groups of control and treatment conditions. There were two phases in the intervention namely learning phase and test phase. At Learning phase students were taught according to either a traditional procedure or according to worked examples effect of cognitive load theory. At test phase all students (control condition and treatment condition) were presented a common test (Scholastic Achievement Test). During the learning phase student's performance in the form of errors committed and cognitive load experienced were recorded. During the test phase student's performance and cognitive load experienced were recorded. The study revealed that students who studied worked examples committed fewer errors and experienced low cognitive load. Students who studied worked examples performed better and experienced less cognitive load than students who solved the same number of problems. It is recommended to give more emphasis on worked examples to improve the performance of children in mathematics and to reduce the cognitive load experienced by students in mathematics.

***Keywords:*** *Mathematics Learning, Cognitive Load, Worked Examples*

**W**hile considerable progress has been made in independent India in providing schooling facilities to all children, children's learning (especially in 3 R's-Reading, Writing and Arithmetic) at primary and elementary level remains a tenuous area. The committee constituted by Ministry of Human Resource Development in November 2015 to formulate a draft national

[1] ICSSR Post-Doctoral Fellow, Dept. of Psychology, Osmania University, Hyderabad, India
*Responding Author

**Received: February 11, 2017; Revision Received: February 24, 2017; Accepted: February 28, 2017**

education policy observed various evaluation studies showing a decline in learning levels among school children. National Achievement Survey confirms the findings from a number of other studies such as ASER, Educational Initiatives etc. and identifies poor learning out comes as the biggest challenge facing Indian education (Government of India, 2016).

***Mathematics-Major Concerns***

Mathematics is a compulsory subject at school level. But unfortunately not only it is still a subject that is considered difficult (high level of cognitive load) but also the performance is not satisfactory. Various studies evidence of very poor learning levels among children in mathematics (ASER, 2015: Education Initiatives, 2010; Pratham, 2005-2010; NCERT, 2008).Even though some curricular reforms based on NCF, 2005 have been implemented there is still an urgent need to improve it further. The present study is an attempt in this direction by using cognitive load theory.

***Cognitive Load Theory- Reduction of Cognitive Load-The worked example effect***

Cognitive load theory (CLT) is one of the most influential and a highly effective guide for the design of multimedia and other learning materials (Plass, Moreno & Brunken, 2010).The aim of CLT is to use our knowledge of human cognition to provide instructional design principles (Sweller, Ayres & Kalyuga, 2011).We process information in working memory. Processing imposes a load. Cognitive load refers to the total amount of load imposed on working memory while processing or performing a task. If the cognitive load exceeds the limit of working memory capacity then the learning process affected (Yuan et al, 2006).

According to Plass, van Moreno, & Brunken (2010) in discovery and problem solving based instructional procedures learners experience high cognitive load. According to Sweller (1988) conventional problem solving imposes high cognitive load. Learning from worked out examples is better than a single example followed by problems. Learners should be presented with several examples rather than a single example, as it is commonly the case (Alexander& Robert, 2010).The paired alternation strategy of worked example was employed in the present study. Sweller and Cooper (1985) first adopted this strategy. Many laboratory experiments and some classroom studies provide support in favour of worked examples (Renkl, 1997; 2002; Sweller ,1999; Sweller and Cooper ,1985; Ward and Sweller ,1990).Worked out examples have shown to be superior to conventional problems (Sweller, 1988).

***Objectives***

1. To analyze the role of worked examples in learning mathematics.
2. To design and conduct an intervention to reduce the cognitive load and improve the performance of students in mathematics.

## METHODOLOGY

***Sample***

Sample comprised of 76 students of 6th grade from social welfare schools of Ranga Reddy district of Telangana state.

***Research tools***

**Students' personal data sheet**

Students' personal data sheet was used to collect information like age, gender, community etc,

**Short Self Report Instrument (SSRI)**

Short Self Report Instrument (SSRI) is related to children's learning experiences while learning various subjects and various concepts in mathematics. Short self report instrument was used to measure cognitive load experienced by students while learning problem solving in mathematics.

SSRI was a self rating scale based on subjective rating scale developed by Pass to assess cognitive load directly. Paas assumed that the mental effort during learning and test stage may be an index of cognitive load which can be obtained from learners through introspection. Learners were asked to rate the mental effort on a 9-point Likert scale with very, very low mental effort(1) to very, very high mental effort(9). The reliability of the scale was found high (Pass, van Merrienboer, & Adam, 1994).Pass (1992) found the internal consistency coefficient (Cronbach's Alpha) of the scale as 0.90, according to Pass & Van Merrienboer(1994) it was found as 0.82.Self rating scale of Pass emerged as the most sensitive measure of cognitive load. According to Sweller, Ayres & Kalyuga(2011) subjective measures can be obtained easily and quickly and it is easy to administer.

Pass self rating scale was widely used by many researchers with modification of wording like asking learners to rate their learning experience as how easy or difficult instead of mental effort. Modified version of the scale was used in the present study. It requires children to rate their learning experience on a 9 point scale ranging from extremely easy (1) to extremely difficult (9)

**Exercise (Practice Material-Intervention)**

It was related to multiplying 3 numbers (ranging from 1 digit to 4 digits) by using commutative and associative properties.

**Scholastic Achievement Test (Post -Test)**

Scholastic Achievement Test was used to assess post test performance and cognitive load experienced at test stage of experimental and control groups after intervention.

***Design and Procedure***

The study was conducted on the children from social welfare schools of Telangana state after taking permission from the government. The secretary, Telangana Social Welfare Residential Educational Institutions Society (TSWREIS) has given formal permission to interact with the students and mathematics teachers to collect the data. After fixing the tentative time schedule for the study consent was obtained from the concerned school principals, mathematics teachers and students. The sample was divided in to two groups of control and treatment conditions. Students were randomly allotted to either the treatment or control condition. In order to control the differences of dependent variables a pre test was given before intervention. After an intervention a post test was administered to both groups.

***Intervention***

There were two phases in the intervention namely learning phase and test phase. Learning phase is also known as acquisition phase. During this phase children were taught according to either a traditional procedure or according to an innovative procedure (worked examples effect).

Students in the control group were simply asked to solve 6 problems as one might ask students in a home work assignment (exercise) in typical mathematics teaching. Students in the treatment condition alternate between 3 pairs of worked examples and problems. In the class beginning the teacher had a discussion around a concept. After the discussion an example solution was presented followed by solving a problem on their own in small groups. The teacher then directed the class back to studying an example. After studying this worked example, the students are given a second problem to solve. Again, this follows the principle worked example –problem pair. It was observed that by having problems to solve in between the worked examples, students are motivated to pay more attention to the worked example because it helps them prepare for the next problem.

A second phase which is known as the test phase followed the learning phase in which all children (control condition and treatment condition) were presented a common test (Scholastic Achievement Test) to see if there were any differences in learning outcomes related to performance and cognitive load experienced. During the learning phase children's performance in the form of errors committed and cognitive load experienced were recorded. During the test phase children's performance and cognitive load experienced were recorded.

## RESULTS

***Table 1 Comparative Mean performance of Students***

| Performance indicator | Control Group | Experimental Group |
|---|---|---|
| Errors committed at Concept acquisition stage | 18 | 4 |
| Score achieved at Scholastic Achievement Test stage | 8.4 | 18.4 |

***Table 2 Mean Cognitive Load experienced by students***

| Cognitive Load | Control Group | Experimental Group |
|---|---|---|
| Concept acquisition stage | 5.0 | 2.2 |
| Scholastic Achievement Test Stage | 4.7 | 2.6 |

***Table 3 Comparative cognitive efficiency***

| Group | N | Cognitive Efficiency (Mean) | Standard Deviation |
|---|---|---|---|
| Control Group | 37 | 9.3 | 9.0 |
| Experimental Group | 39 | 10.8 | 8.9 |

## DISCUSSION

Students who studied worked examples committed fewer errors (table 1) and experienced low cognitive load (table 2) than students who solved the same number of problems at learning phase. Students who studied worked examples performed better (table 1) and experienced less cognitive load (table 2) than students who solved the same number of problems. Mean cognitive efficiency of the Experimental Group is higher than the mean cognitive efficiency of the control group(Table 3).Efficiency of a method can be calculated as a ratio of test performance and invested mental effort (cognitive load) (Pass &Van Merrienboer,1993).The benefits of worked examples for improving learning efficiency and learning outcomes have been demonstrated in many previous studies (Cooper and Sweller,1987; Kirshner, Sweller & Clark ,2006; Renkl ,1997: Ward & Sweller ,1990).

Mathematical educators have started recognising the importance of worked examples in problem solving. Department of education, USA in its report Organising Instruction and Study to Improve Student Learning recognised the importance of worked examples, the report says: ” When teaching mathematical or science problem solving, we recommend that teachers interleave worked example solutions and problem-solving exercises—literally alternating between worked examples demonstrating one possible solution path and problems that the student is asked to solve for himself or herself—because research has shown that this interleaving markedly enhances student learning” (Pashler,et al.,2007 ,p 20).The report recommended (as recommendation-2) worked examples strategy in the teaching learning process with the following checklist..

1. Have students alternate between reading already worked solutions and trying to solve problems on their own
2. As students develop greater expertise, reduce the number of worked examples provided and increase the number of problems that students solve independently (Pashler, et al.,2007 ,p 15).

## CONCLUSION

The findings of the present study have clear implications for mathematical educators. There is an urgent need to give more emphasis on cognitive load effects such as worked examples to improve the performance of children in mathematics and reduce the cognitive load while learning mathematical problem solving.

***Acknowledgements***

This work is a part of the study (Post Doctoral Fellowship) funded by Indian Council of Social Science Research (ICSSR), New Delhi.

***Conflict of Interests:*** The author declared no conflict of interests.

## REFERENCES

Alexander, R. & Robert, K.A., (2010). Learning from worked – out examples and problems solving. In Plass, J.L, Moren, R., Brunken, R. (Eds), *Cognitive Load Theory* (PP 91-108). New York: Cambridge University Press.

*Education Initiatives, (2010). Student Learning Study. Ahmedabad: EI*Government of India (2016). *National Policy on Education.* Report of the committee for evolution of new education policy New Delhi: Ministry of Human Resource and Development.

Kirschner, P.A., Sweller, J., &Clark, R.E. (2006). Why minimal guidance during instruction does not work: An analysis of the failure of constructivist, discovery, problem-based, experiential, and inquiry-based teaching. *Educational Psychologist, 41,* 75–86.

*National Council of Educational Research and Training, (2008). National Achievement Survey, 2008. New Delhi: GOI-MHRD.*

Paas, F.,& van Merriënboer, J. (1994). Variability of worked examples and transfer of geometrical problem-solving skills: A cognitive-load approach. *Journal of Educational Psychology, 86,* 122–133

Pashler, H., Bain, P., Bottge, B., Graesser, A., Koedinger, K., McDaniel, M., and Metcalfe, J. (2007) *Organizing Instruction and Study to Improve Student Learning* (NCER 2007-2004). Washington, DC: National Center for Education Research, Institute of Education Sciences, U.S. Department of Education. Retrieved from http://ncer.ed.gov.

Pass,F.G.(1992).Training strategies for attaining transfer of problem solving skill in statistics: A cognitive load approach. *Journal of Educational Psychology*,84,429-434.

Pass,F.G.W.C.,Van Merrienboer,J.J.G.(1993).The efficiency of instructional conditions: an approach to combine mental effort and performance measures. *Human Factors*,35,737-743.

Pass,F.G.W.C., Van Merrienboer ,J.J.G., & Adam J.J.(1994).Measurement of cognitive load in instructional research. *Perceptual and Motor Skills*,79,419-430.

Plass, J.L, Moreno, R., Brunken, R. (2010). *Cognitive Load Theory*, Cambridge ,Cambridge University Press.

*Pratham, (2005-2010). Annual Status of Education Report (rural). Mumbai: Pratham*

Renkl, A. (1997). Learning from worked-out examples: A study on individual differences *Cognitive Science, 21,* 1–29.

Renkl, A. (2002). Worked-out examples: Instructional explanations support learning by self-explanations. *Learning and Instruction, 12,* 529-556.

Sweller, J. (1999). *Instructional design in technical areas* Victoria, Australia: Australian Council for Education Press.

Sweller, J., & Cooper,G.A,.(1985).The use of worked examples as a substitute for problem solving in learning algebra. *Cognition and instruction*,, 2,59-89.

Sweller,J.(1988),Cognitive load during problem solving: Effects on learning, *cognitive science* 12,257-285

Sweller,J., Ayres,P., Kalyuga,S.(2011), *Cognitive load theory, explorations in the learning sciences, instructional systems and performance technologies*, New York, Springer

*The Annual Status of Education Report (Rural)*, 2014(2015). ASER Centre, New Delhi.

Ward, M., & Sweller, J. (1990). Structuring effective worked examples. *Cognition and Instruction, 7,* 1-39

Yuan,K.,Steedle.J.,Shavelson.R.,Alonzo.A.,Oppezzo.M.(2006).Working memory, fluid intelligence and science learning. Educational Research Review,1,83-98.

**How to cite this article:** Rao V (2017), Problem Solving In Mathematics-Role of Worked Examples in Reducing Cognitive Load and Improving Scholastic Performance, *International Journal of Indian Psychology*, Volume 4, Issue 2, No. 92, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.120/20170402, ISBN:978-1-365-78192-6

The International Journal of
# INDIAN PSYCHOLOGY

## Submission open for Volume 4, 2017

The International Journal of Indian Psychology is proud to accept proposals for our 2013 to 2015 Issues. We hope you will be able to join us. For more information, visit our official site: www.ijip.in

**Submit your Paper to,**
At via site: http://ijip.in/index.php/submit-paper.html OR Email: info.ijip@gmail.com

**Topics:**
All areas related to Psychological research fields are covered under IJIP.

**Benefits to Authors:**
- Easy & Rapid Paper publication Process
- IJIP provides "Hard copy of full Paper" to Author, in case author's requirement.
- IJIP provides individual Soft Copy of "Certificate of Publication" to each Author of paper.
- Full Color soft Copy of paper with Journal Cover Pages for Printing
- Paper will publish online as well as in Hard copy of journal.
- Open Access Journal Database for High visibility and promotion of your research work.
- Inclusions in all Major Bibliographic open Journal Databases like Google Scholar.
- A global list of prestigious academic journal reviewers including from WHO, University of Leipzing, University Berlin, University Hamburg, Sardar Patel University & other leading colleges & universities, networked through RED'SHINE Publication. Inc.
- Access to Featured rich IJIP Author Account (Lifetime)

**Formal Conditions of Acceptance:**
- Papers will only be published in English.
- All papers are refereed, and the Editor reserves the right to refuse any manuscript, whether on invitation or otherwise, and to make suggestions and/or modifications before publication.

**Publication Fees:**
Rs 600/- OR $ 18 USD for Online and Print Publication (All authors' certificates are involved)
Rs 300/- per Hardcopy (Size A4 with standard Biding)

## Use Our New Helpline Number: 0 76988 26988

Edited, Printed and Published by RED'SHINE Publication. (India) Inc.
on behalf of the RED'MAGIC Networks. Inc. (www.redmac.in)
86: Shradhdha, 88 Navamuvada, Lunawada, Gujarat-389230
www.redshinepub.eu.pn | info.redshine@asia.com | Co.no: +91 76988 26988
www.ijip.in | info.ijip@gmail.com | journal@ijip.in

Indexed at
Google Scholar | Internet Archive | Google Books | Available on iTunes | GET IT ON Google Play

Published by | Cover page designed by | Website designed by
red'shine Publication | RED'SHINE Studios | red IT SOLUTION